# Implementation of the "Becca" Bill: A Process Evaluation

**Final Report**
Revised
February, 1998

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Acknowledgments

I would like to thank all of the interview repondents for their time and for sharing their experience with and thoughts about the "Becca" Bill and adolescent chemical dependency treatment. I would also like to thank Mark Biernbaum for his research and interviewing assistance, Julie Sayed for her interviewing assistance, and Caleb Banta-Green for his help with the final version of this report.

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## INTRODUCTION

In July, 1995, the Washington State legislature enacted the At-Risk/Runaway Youth Act (Engrossed Second Substitute Senate Bill 5439, Chapter 312, Laws of 1995), known as the "Becca" Bill. This law was named after Rebecca Hedman, a runaway youth who was killed on the streets after running from treatment The law's intent was to help parents of runaway or at-risk youth regain control over their children and to obtain chemical dependency and mental health treatment for their children who were in need of these services. To this end, the legislation modified parental consent procedures for minor children, modified court procedures to compel children to enter treatment, authorized law enforcement to take runaway/at-risk youth to their parents' home or secure crisis residential centers, and established procedures for reporting and enforcing truancy laws.

The Division of Alcohol and Substance Abuse (DASA) contracted with the University of Washington's Alcohol and Drug Abuse Institute to conduct a process evaluation of the implementation of the "Becca" Bill. The main purpose of the process evaluation was to provide a broad overview of implementation issues for the "Becca" Bill, with particular emphasis on the portions of the Bill related to chemical dependency treatment. A secondary goal was to provide information on how adolescent chemical dependency treatment is viewed by professionals who work with at-risk adolescents.

## METHOD

Phone-interviews were conducted with 98 key informants--people selected because they would be knowledgeable about the implementation of the "Becca" Bill within their organization or jurisdiction. The interviews were conducted from late June, 1996 through September, 1996.

### Sample Selection

Key informants were selected from the systems most directly affected by the "Becca" Bill: chemical dependency (CD) service agencies (n=21), mental health (MH) agencies (n=13), youth services including shelters and crisis residential centers (n=13), Division of Children and Family Services (DCFS) (n=10), the judicial system (n=14), law enforcement (n=13), and schools (n=14). Because of potentially different implementation challenges and resources between regions and rural/urban areas, respondents were roughly balanced rural western and eastern Washington counties. Respondents were drawn from eight counties; five counties in western Washington (King, Pierce, Thurston, and Whatcom), with 1 of these on the Olympic Peninsula (Clallam), and three counties in eastern Washington (Kittitas, Spokane, and Yakima).

The sample is a purposive sample and is not representative of a population. The positions of people interviewed vary by county, in part reflecting that people who are knowledgeable or involved with the "Becca" Bill implementation vary by county, as well as reflecting the ability or willingness of initial contacts to take the time for the interview. In general, depth within particular agency types was sacrificed in favor of breadth across agency types and regions.

We provide results by agency type for descriptive purposes. However, the number of respondents for each type of agency is small (between 10 and 21) and what may appear as large differences between agency types may be due to only a few people. Thus, any differences must be interpreted cautiously and as only suggestive.

## RESULTS

### I. IMPLEMENTATION OF THE "BECCA" BILL

**Changes Made By Agencies In Response To The "Becca" Bill**
Respondents were asked whether their agency or department had made any operational or procedural changes in order to implement the legislation.

- 70% or more of DCFS, Courts, and school respondents reported changes were made to implement the Bill.

- Less than half of chemical dependency or law enforcement respondents indicated they had made changes.

Law enforcement officers in particular noted the lack of crisis residential centers (CRCs), and the lack of resources allocated in the Bill for transporting youth, as important reasons no changes had been made. For chemical dependency treatment, the legislation in fact changed very little in terms of residential treatment admissions. Parents had always had the right to admit youth to treatment without their consent, although parents may not have been aware of that right.

**Barriers to Implementation**
We asked respondents what types of barriers they had faced in implementing the "Becca" Bill, and then asked about seven specific potential barriers that had been gleaned from sources such as meetings where the "Becca" Bill was discussed and newspaper reports on the "Becca" Bill. Each barrier was rated by respondents on a three-point scale to reflect how much of a problem it was for their agency from "not at all a problem" to "a major problem."

- The three most important implementation barriers faced across agencies were:
    - Lack of youth shelters and other youth services
    - Lack of secure CRCs, and
    - Lack of financial resources allocated for implementation.

<u>Lack of shelters and other youth services</u>
- 70% or more of Youth Service, DCFS, and mental health respondents viewed the lack of youth shelters as a major problem.

<u>Lack of secure CRCs</u>
- 80% or more of all respondents, except those from youth shelters/other services and schools, viewed the lack of secure CRCs as somewhat of a problem or a major problem.

- Youth service agencies were nearly evenly divided between viewing lack of secure crisis residential centers as either not a problem (54%) or a major problem (46%), with no one viewing it as somewhat a problem.

Lack of financial resources

- Well over 50% of the respondents from all agency types, with the exception of chemical dependency agencies, saw lack of financial resources as a major implementation barrier.

- All of the judicial and school respondents perceived lack of resources as at least somewhat of a barrier.

Confusion about the legislation

- Over half of respondents in all types of agencies, except law enforcement, viewed confusion about the legislation as a barrier to implementation. All of the respondents from DCFS saw confusion over the legislation as at least somewhat a problem.

- Confusion about the legislation was seen as a major implementation barrier by over half of the respondents from youth service agencies and mental health treatment agencies.

Additional workload

- 86% of court, and 79% of school respondents reported increased workload attributed to the "Becca" Bill as a major barrier.

Concern over youth rights

- About 50% of mental health and youth service agency respondents reported that concern over violating youth rights was a major implementation barrier, compared to about 10 % of chemical dependency treatment and judicial respondents.

Concern that youth will stay away from social services

- About 70% of youth service and 50% of mental health respondents viewed concern over youth staying away from social services due to the "Becca" Bill as an implementation barrier compared to 20-30% of respondents from other types of agencies.

## II. PERCEIVED IMPACT OF THE "BECCA" BILL

### Impact of the Bill on Youth and Parents

- Over two-thirds of respondents from chemical dependency treatment agencies, DCFS, the judicial system and schools felt the Bill had a more positive than negative impact on runaway youth. None of the respondents from youth service agencies and less than half of the respondents from mental health treatment agencies felt that it had a more positive than negative impact.

- With the exception of youth service agencies, the majority of respondents felt that the Bill had a more positive than negative impact on parents.

### Perceived Impact of the Bill on Improving Treatment Access

We asked respondents how successful they believed the Bill was in helping parents obtain chemical dependency treatment for their adolescent children who have run away from home and were abusing drugs.

- About 60% of the chemical dependency treatment agencies and DCFS respondents thought it was somewhat to very successful, about 75% of judicial system respondents thought it

was somewhat successful, and none of the respondents representing youth service agencies or shelters thought it was successful.

**Impact of "Becca" Admissions on Chemical Dependency Treatment Agencies**

- Very few of the respondents representing residential chemical dependency treatment agencies felt that "Becca" youth were any different from other youth they serve, or that admitting "Becca" youth had had any impact on the treatment milieu of their agency. The number of "Becca" youth who had been admitted to any one agency at the time of the interview was small.
- About half (46%) of the respondents felt that the families of "Becca" youth presented special challenges.
- Respondents from about a third of treatment agencies in the sample said that admission of "Becca" youth had resulted in admission delays for non-"Becca" youth.

**Impact of Bill on the Development of Interagency Linkages**

We asked respondents whether, as a result of the "Becca" Bill, their agency had developed new or stronger linkages with any of the other systems.

- Over 50% of the judicial system respondents reported new or stronger linkages with schools, and about 30% reported new or stronger linkages with DCFS.

## III. SUMMARY: PERCEIVED STRENGTHS AND WEAKNESSES OF THE BILL

Respondents were asked using open-ended questions what they perceived as the main strengths and weaknesses of the Bill, and what recommendations they could offer for improving the legislation.

**Perceptions of the Major Strengths of the Bill**

- The main strengths of the "Becca" Bill mentioned by respondents were that it:
    - Had a positive impact on parents (increasing their control, authority, helping parents get youth into treatment) (52%),
    - Had a positive impact on youth (helping youth get into treatment, helping youth get other types of assistance) (28%),
    - Brought statewide attention to important issues (awareness of runaway issues, truancy issues, need for more treatment) (28%),
    - Had a positive effect on truancy (reduced truancy, created processes to address truancy, increased youth and parent accountable for truancy) (18%).

**Perceptions of the Major Weaknesses of the Bill**

The main weaknesses of the Bill mentioned by respondents were:

- Confusion over the Bill and how to implement it (26%)
- Unfunded mandates (24%)
- Parent/Family Issues: increased parent frustration, put courts between parents and children (19%)

- Youth Issues: blamed youth for running from bad situation, violated civil rights of youth, decreased service use by youth (17%)
- Lack of chemical dependency treatment: Bill doesn't provide for more treatment, lack of locked chemical dependency treatment, problems with coerced treatment (16%)
- Lack of secure CRCs (15%).

**Recommendations for Improving the "Becca" Bill**
The top five recommendations for improving the Bill were:

- Increase funding for implementation (42%)
- Increase chemical dependency treatment services and treatment access for youth (27%)
- Parent/Family issues: Increase parent responsibility/accountability, increase focus on families and not just youth (24%)
- Get secure CRCs up and running (20%)
- Add funding/focus on public education and prevention (19%)

## IV. PERCEPTIONS OF ADOLESCENT CHEMICAL DEPENDENCY TREATMENT

**Perceived Treatment Effectiveness**

- Over half of the respondents perceived adolescent chemical dependency treatment to be moderately to very effective. Residential treatment was rated as more effective than outpatient treatment.
    - 68% of respondents perceived inpatient treatment as moderately to very effective
    - 58% of respondents perceived outpatient treatment as moderately to very effective.

**Treatment Accessibility and Treatment Barriers**

- Outpatient treatment was seen as more accessible than residential treatment.
    - 32% of respondents viewed outpatient treatment to be difficult to very difficult to access, compared to 81% of respondents regarding residential treatment.
- The main barriers to youth receiving inpatient treatment perceived by respondents were: treatment availability (68%), funding (67%), and youth motivation (20%).
- The main barriers to youth receiving outpatient treatment cited by respondents were: financial barriers (44%), youth motivation (38%), lack of treatment availability particularly in non-urban areas (23%), and lack of parental support or involvement (23%).

**Respondent Recommendations**
Respondents were asked their recommendations for improving both adolescent residential and outpatient chemical dependency treatment .

<u>Outpatient Treatment</u>
The top five recommendations for outpatient treatment were :

- Improve outreach and coordination with other service providers particularly residential treatment, mental health treatment, and schools; provide case management

- Increase funding for treatment
- Improve treatment models used
- Increase treatment access (particularly in non-urban areas and for middle school students)
- Improve program structures such as increasing treatment length and intensity; improve staff training

Residential Treatment

The top five recommendations for improving residential treatment were:

- Increase treatment availability (more programs, reduce waitlists, provide treatment on demand).
- Increase funding for residential treatment
- Improve aftercare services and linkages between residential treatment and other service providers
- Improve treatment access (e.g., cultural, language and geographic barriers)
- Improve program structures (e.g., longer treatment and improved staff training)

## CONCLUSION

From the interviews with key informants across multiple systems, it is clear that there are disparate perspectives on the wisdom of the "Becca" Bill and on its impact on youth and parents. Most of the respondents agreed that something needs to be done for runaway and at-risk youth; there was less agreement on what and how it should be done.

One issue centers around the role of parents. In general, people felt that the Bill had a more positive impact on parents than on youth. The most frequently cited strength of the Bill was that, with the threat of the court sanctions behind them, it increased parental control and authority over their children as well as it increased parental access to treatment for their children. However, one of the commonly cited weaknesses of the Bill was that it went too far increasing parents control without increasing parental accountability. Recommendations from respondents included giving courts more authority over parents such as the ability to order drug treatment for parents as one of the petition conditions and including parent or family evaluations when evaluating youth.

A second issue in which there were discrepant views centered around placing youth in locked facilities and in treatment against their will or without their consent. Some of the respondents believed quite strongly that some of these youth are so out of control that the only way to keep them from running long enough to help them is to place them in secure facilities where they can have a time to "chill out" and where they can be evaluated. Similarly, some believe that denial is part of the disease of addiction and that for some minors the only way they will get into treatment is if they are placed their against their will.

Other respondents believed equally strongly that placing youth in locked facilities or in treatment against their will, was counterproductive, further alienated youth and drove them more "underground". Many respondents believed that treatment would only be effective if youth were motivated, and that placing youth in treatment against their will was essentially pointless.

In fact, lack of youth motivation was one of the most commonly cited barriers to effective treatment. Innovative programs and strategies to work with youth, increase their motivation and treatment readiness, and methods for retaining youth in treatment, are also needed. It was beyond the scope of this evaluation to more directly assess the impact of the legislation on runaway or at-risk youth. However, this is a critical missing piece and warrants investigation.

There was somewhat wider agreement as to implementation barriers. One of the most frequently cited barriers was the lack of shelters or other youth services and the lack of secure crisis residential centers.

Another important barrier was the lack of resources allocated for implementing the Bill. The most frequent recommendation by respondents was that in order for this legislation to be implemented effectively, more resources were needed.

Respondents across systems recommended that more resources be provided for publicly funded chemical dependency treatment for youth. Placing youth on waiting lists for treatment was seen as a major problem, resulting in losing youth and missing windows of opportunities to intervene. Outpatient treatment was viewed as more accessible than inpatient treatment, but particularly in rural areas, the lack of programs close by was seen as an important barrier.

Overall, chemical dependency treatment was viewed as moderately to very effective, with residential treatment viewed as more effective than outpatient treatment. However, in addition to increasing treatment availability, several recommendations were offered for improving treatment services. One frequent recommendation was that treatment program models be changed to provide treatment that is more appropriate for adolescents, provide more family systems based treatment, and provide alternatives to the 12-step or disease models.

A second recommendation was that the chemical dependency treatment programs do more outreach and work more closely with other agencies including school, outpatient treatment, and mental health treatment providers. Primary concerns were that there need to be more after-care programs, case management, stronger linkages between residential and outpatient programs, and improved services for dually diagnosed youth. There was a perception among many respondents that chemical dependency treatment programs are turning away, or not able to retain, youth with mental health or behavioral problems.

Key informants were selected for their knowledge or involvement in the implementation of the "Becca" Bill, and not their knowledge of chemical dependency treatment programs. Thus, their views may not be based on accurate information. Nevertheless, the consistency and conviction with which some of these views or concerns were expressed suggests that they warrant examination and discussion. It also suggests that at the very least there is a need for more outreach and education about chemical dependency services, treatment models, and admission procedures and requirements.

# OVERVIEW

In July, 1995, the Washington State legislature enacted the At-Risk/Runaway Youth Act (Engrossed Second Substitute Senate Bill 5439, Chapter 312, Laws of 1995), known as the "Becca" Bill. This law was named after Rebecca Hedman, a runaway youth who was killed on the streets after running from treatment The law's intent was to help parents of runaway or at-risk youth regain control over their children and to obtain chemical dependency and mental health treatment for their children who were in need of these services. To this end, the legislation modified parental consent procedures for minor children, modified court procedures to compel children to enter treatment, authorized law enforcement to take runaway/at-risk youth to their parents' home or secure crisis residential centers, and established procedures for reporting and enforcing truancy laws.

The Division of Alcohol and Substance Abuse (DASA) contracted with the University of Washington's Alcohol and Drug Abuse Institute to conduct a process evaluation of the implementation of the "Becca" Bill. The main purpose of the process evaluation was to provide a broad overview of implementation issues for the "Becca" Bill, with particular emphasis on the portions of the Bill related to chemical dependency treatment. A secondary goal was to provide information on how adolescent chemical dependency treatment is viewed by professionals who work with at-risk adolescents.

The process evaluation was developed to answer the following questions:

**"Becca" Bill Implementation**

- What is the understanding of the intent of the "Becca" Bill by agency stakeholders -- people in agencies and systems most directly impacted by the "Becca" Bill?
- What have been the main obstacles to the implementation of the "Becca" Bill policy?
- What have been the perceived positive and negative effects of the "Becca" Bill for youth, families, and agencies?
- What recommendations do stakeholders have for improving this policy?

**Perceptions of Adolescent Chemical Dependency Treatment**

- How do people who work with at-risk youth view adolescent chemical dependency treatment in terms of effectiveness and accessibility?
- What recommendation do respondents have for improving adolescent chemical dependency treatment services?

# METHOD

Phone-interviews were conducted with key informant stakeholders -- people selected because they would be knowledgeable about the implementation of the "Becca" Bill within their organization or jurisdiction. The interviews were conducted from late June, 1996 through September, 1996. The interview was structured with both forced choice questions (e.g., using a 1 to 4 response scale or yes/no response format) and open-ended questions. Often the open-ended response was used to expand on the respondents' closed-ended (forced choice) response. The forced choice responses more readily allow for quantitative summaries of results, whereas the open-ended question allow for a more comprehensive understanding of the response. A copy of the interview is in the appendix.

## Sample Selection

The "Becca" Bill legislated changes across multiple systems. Key informant respondents were drawn from systems most directly affected by the "Becca" Bill: chemical dependency (CD) service agencies, mental health (MH) agencies, youth services including shelters and crisis residential centers, Division of Children and Family Services (DCFS), the judicial system, law enforcement, and schools.

Because of potentially different implementation challenges and resources between regions and rural/urban areas, respondents were roughly balanced between rural western and eastern Washington counties. Counties in eastern and western Washington that had the largest number of adolescents admitted to residential treatment under the auspices off the "Becca" Bill as of June, 1996 were selected[1]. Respondents were drawn from eight counties; five counties in western Washington (King, Pierce, Clallam, Thurston, and Whatcom), with 1 of these on the Olympic Peninsula (Clallam), and three counties in eastern Washington (Kittitas, Spokane, and Yakima). In addition, we interviewed one residential treatment agency in Skagit County that had several "Becca" admissions and was part of the treatment outcome evaluation for the "Becca" Bill. Table 1 presents the counties selected and the number of respondents from each county by type of agency. "Becca admissions" were defined by DASA as youth admitted with an At-Risk Youth (ARY) petition, Child in Need of Services (CHINS) petition, Involuntary Commitment, Truancy petition, or a voluntary parent admission without youth consent.

**Table 1: Number of Respondents by Agency Type and County**

| | Western Washington | | | | Olympic Peninsula | Eastern Washington | | | TOTAL |
|---|---|---|---|---|---|---|---|---|---|
| | King | Pierce | Thurston | Whatcom | Clallam | Kittitas | Spokane | Yakima | |
| • Chemical Dependency | 8 | 2 | 2 | 2 | 0[A] | 2 | 2 | 2 | 21[B] |
| • Youth Services | 6 | 6 | 2 | 1 | 0 | 1 | 1 | 1 | 13 |
| • DCFS | 2 | 2 | 1 | 1 | 2 | 1 | 1 | 1 | 10 |
| • Mental Health | 2 | 1 | 1 | 2 | 2 | 1 | 1 | 4 | 13 |
| • Courts | 3 | 1 | 1 | 1 | 2 | 1 | 1 | 4 | 14 |
| • Law Enforcement | 1 | 2 | 2 | 1 | 1 | 1 | 2 | 3 | 13 |
| • Schools | 3 | 2 | 1 | 1 | 1 | 1 | 2 | 4 | 14 |
| TOTAL | 24 | 10 | 10 | 9 | 8 | 7 | 10 | 19 | 98 |

[A] One of the agencies coded as mental health also provides adolescent outpatient chemical dependency treatment services.

[B] One residential treatment agency that is part of the "Becca" Bill outcome evaluation was included. It is in Skagit county and was not shown in this table, bringing the total number of chemical dependency treatment agencies to 21.

Key informants were selected using multiple sources and snowball sampling methods. We contacted people at DASA, Office of the Administration of the Courts, Office of the Superintendent of Public Instruction (OSPI), and Division of Children and Family Services (DCFS) to obtain names of initial contacts in their system. In areas or types of agencies where we had no specific name, we contacted a high level administrator for the names of appropriate people. We also asked respondents to recommend key informants. A summary of the sources of initial contact by type of agency is described below.

**Chemical Dependent Treatment**

- Initial contacts were selected from certified Adolescent Residential and Outpatient Chemical Dependency Treatment Agencies. Initial contacts were made with agency directors or directors of treatment programs.

**Youth Services**

- Respondents were selected from a list of Crisis Residential Center Administrators, provided by DSHS.
- Lists of shelters and children's advocacy service agencies across the state, provided by Northwest Network of Runaway & Youth Services and Center for Human Services
- Partnership for Youth, a coalition of youth service providers including shelters, city and county social service staff, local businesses, community police officers, and other community organizations, provided referrals for key informants at shelters and children's advocacy/service agencies in the Seattle area.

**Mental Health Treatment**

- Initial contacts were selected from a list of Division of Mental Health Children's Resource Managers from each Regional Support Network (RSN). RSNs serve as the regional administrative body for public mental health services. These individuals monitor and coordinate mental health services for children and youth at county and regional levels.

**DSHS/DCFS**

- Contacts were selected from a directory of all regional and county-level DCFS offices and their staff. When possible, Family Reconciliation Services (FRS) supervisors were the initial contacts. Otherwise, Child Protective Services (CPS) supervisors, area managers, and regional administrators were contacted.

**Courts**

Office of the Administration for the Courts provided two lists from which initial contacts in the court system were drawn:

- 1995/96 Family Juvenile Law Committee: This list consists of members of the current Family Juvenile Law Committee. Members are Superior Court judges with an interest in family law-related issues, Superior Court commissioners, tribal court judges and liaisons, a senate liaison, and a state bar association liaison. These judges adjudicate truancy, ARY and CHINS petitions.

- Washington Association of Juvenile Court Administrators: This list includes all juvenile court administrators across the state, as well as key employees of the DSHS/Juvenile Rehabilitation Administration (such as statewide coordinators of community programs and all regional coordinators).

**Law Enforcement**

Respondents were selected from the Washington Association of Sheriffs and Police Chiefs (WASPC) 1995-1996 Law Enforcement Directory. Initial contacts were police chiefs and county sheriffs.

**Schools**

The Office of Superintendent of Public Instruction provided lists of administrators of drug prevention programs within Educational Service Districts and School Districts across the state.

**Multiple System Resources**

- List of participants of a workshop on the "Becca" Bill sponsored by Sundown M Ranch; participants came from many areas and agencies, including drug/alcohol treatment agencies, mental health treatment agencies, county and tribal court systems, school districts, and law enforcement agencies, mostly from Yakima County.
- Youth Focus Group, a statewide group of chemical dependency, mental health, and juvenile justice professionals; DASA provided recommendations for key informants.
- Newspaper articles: a newsclipping service provided articles in papers across the state regarding the "Becca" Bill, parents' rights, adolescent drug abuse, and runaway youth. Specific agencies or groups mentioned in these articles, if their connection to the legislation was clear, were included as potential key informants. Types of agencies from this source include chemical dependency treatment agencies, children's rights advocacy groups, law enforcement agencies, schools, parents' rights advocacy groups, shelters, and other youth service agencies.

## Procedures

Potential respondents were contacted by phone. The interview purpose was described, and the person was asked whether they would be the appropriate person in their agency or system to complete the interview, and if not, who they would suggest. Respondents were also asked for names of people in other systems in their area who would be knowledgeable about the "Becca" Bill. Of the 144 people contacted for an interview, 44 (30%) declined to be interviewed themselves, and two interviewees were determined not to be appropriate and the interview was not completed, bringing the total number of interviews to 98. Most who declined to be interviewed did so because they felt someone else was more appropriate. All of those who declined to be interviewed provided us with key informant names.

When contacted for an interview, the purpose and content was again described, and we requested consent to audio-record portions of the interview that contained open-ended responses. No one refused to have the interview recorded, although the recorder malfunctioned for a few (4) interviews. On average, the phone interviews took about 35 minutes to complete. Successfully recorded interviews were transcribed.

Open-ended questions were content coded using the transcriptions. The coding was done by one person. Ninety percent agreement was established between the coder and the research director prior to starting the coding. A twenty percent sample of coded responses was subsequently checked.

## Sample Description

Ninety-eight people were interviewed across eight counties and seven types of agencies/systems. As shown in Table 1, 81 key informants from agencies in western Washington counties were interviewed: 24 in King County, 10 each in Pierce and Thurston counties, 9 in Whatcom county and 8 in Clallam County on the Olympic Peninsula. In eastern Washington, 36 people were interviewed: 7 from Kittitas County, 10 from Spokane County, and 19 from Yakima County. Some of the differences between counties in the number of people interviewed reflects the actual number of services available, particularly chemical dependency and youth services. For example, in Clallam County we were not able to locate any youth shelters. It also reflects our ability to identify and contact appropriate people. For example,

because the interviews needed to be conducted during the summer months, we had difficulty contacting non-administrative school personnel such as counselors in the school drug and alcohol programs. Table 2 presents the types of respondents (position) by type of agency and region.

**Chemical Dependency Treatment (n=21)**

Residential Treatment (n=10)

All residential treatment programs in the selected counties who had "Becca" admissions were included. All six of the agencies participating in the outcome evaluation component of the study were included, one of which was included even though it was not in one of the eight counties selected for the process evaluation.

Of the ten residential treatment programs, five provided Level I, basic residential treatment services, and five provided Level II, intensive residential treatment services. Six of the residential programs also provided outpatient treatment, and four provided residential and aftercare services (all but one of which also provided outpatient treatment services).

Outpatient Treatment (n=11)

There were 11 agencies selected as outpatient chemical dependency treatment agencies and these were selected either through nominations, or using lists provided by DASA of adolescent outpatient treatment agencies. Three of these agencies did not provide direct treatment services, but either administered outpatient treatment contracts to treatment agencies, or provided referral, information, or crisis intervention services. Thus, there were only 8 outpatient treatment agencies. However, an additional 7 agencies reported providing outpatient chemical dependency treatment for adolescents: four youth service agencies, two comprehensive mental health agencies, and one school. Three of these agencies (2 youth service agencies and 1 mental health agency) were listed as outpatient providers in the DASA August, 1995 Directory of Certified Chemical Dependency Treatment Services in Washington state. For the purposes of categorizing agencies for this report, we coded agencies to reflect the major service provided. As seen in Table 2, we interviewed agency and program administrators, managers, and counselors.

## Table 2: Job Title/Position of Interview Respondents, by Agency Type and Region

| Respondent Job Titles/Position | Western Washington | Olympic Peninsula | Eastern Washington | Total |
|---|---|---|---|---|
| **CD Treatment Agencies** | | | | |
| Executive Director | 2 | 0 | 2 | 4 |
| Administrator | 1 | 0 | 1 | 2 |
| Program Manager/Treatment Director | 7 | 0 | 2 | 9 |
| Program Coordinator | 2 | 0 | 0 | 2 |
| Counselor | 3 | 0 | 1 | 4 |
| **Total** | **15** | **0** | **6** | **21** |
| **Youth Services/Shelters/CRCs** | | | | |
| Executive Director | 1 | 0 | 0 | 1 |
| Program Manager, Supervisor, Tx Director | 9 | 0 | 3 | 12 |
| **Total** | **10** | **0** | **3** | **13** |
| **DCFS** | | | | |
| FRS Supervisor | 1 | 0 | 0 | 1 |
| CPS Supervisor | 1 | 0 | 0 | 1 |
| CPS/FRS Supervisor | 1 | 0 | 1 | 2 |
| DCFS Supervisor, All programs | 0 | 2 | 0 | 2 |
| Program Manager | 1 | 0 | 0 | 1 |
| FRS, Social Worker | 1 | 0 | 2 | 3 |
| **Total** | **5** | **2** | **3** | **10** |
| **Mental Health** | | | | |
| RSN Program Manager/Child Resource Manger. | 4 | 0 | 2 | 6 |
| Agency Director | | 1 | 1 | 2 |
| Agency Program Manager, Supervisor | 1 | 1 | 3 | 5 |
| **Total** | **5** | **2** | **6** | **13** |
| **Judicial** | | | | |
| Judge | 1 | 0 | 2 | 3 |
| Commissioner | 4 | 1 | 2 | 7 |
| Juvenile Court Administrator | 0 | 2 | 1 | 3 |
| ARY/CHINS Facilitator | 1 | 0 | 0 | 1 |
| **Total** | **6** | **3** | **5** | **14** |
| **Law Enforcement** | | | | |
| Police Chief | 0 | 0 | 2 | 2 |
| Police Asst. Chief/Captain/Sergeant | 2 | 0 | 1 | 3 |
| Police Officer, Detective, Technical Services Mngr | 3 | 0 | 0 | 3 |
| County Sheriff | 0 | 1 | 3 | 4 |
| Legal Advisor to Sheriff | 1 | 0 | 0 | 1 |
| **Total** | **6** | **1** | **6** | **13** |
| **Schools** | | | | |
| School Principal | 1 | 0 | 1 | 2 |
| Vice Principal/Asst. Principal | 0 | 1 | 1 | 2 |
| Asst. Superintendent Secondary Education | 1 | 0 | 0 | 1 |
| Program Manager, District Drug & Alcohol Programs | 2 | 0 | 0 | 2 |
| Program Manager, Other District Programs | 2 | 0 | 2 | 4 |
| Attendance Officer | 1 | 0 | 0 | 1 |
| Division Director, ESD | 1 | 0 | 1 | 2 |
| **Total** | **8** | **1** | **5** | **14** |

**Youth Services (n=13)**
Nine of the youth services agencies provide temporary shelter for youth, and six of these shelters are designated as regional Crisis Residential Centers (not locked). As noted above, four of the youth service agencies reported providing outpatient chemical dependency treatment services. We interviewed agency directors, and program directors, managers, and supervisors.

**Mental Health Treatment (n=13)**
We only included community mental health centers or RSN program managers (RSN) in the sample and did not include any inpatient mental health providers. The mental health division of DSHS has contracted with Washington State University to conduct an evaluation of the Mental Health component of the "Becca" Bill and that evaluation is focusing on state hospitals. As already noted, two of the comprehensive mental health centers reported providing adolescent chemical dependency treatment. We interviewed RSN child resource managers, agency directors, and agency program managers or supervisors.

**DSHS/DCFS (n=10)**
Where possible, we tried to interview people involved with Family Reconciliation Services (FRS). Who we interviewed in part reflects the size of the population in the County and the structure of the DCFS office. For example, in some counties, the FRS and CPS supervisor positions were staffed by the same person, in other counties these positions were staffed by different individuals. We interviewed administrative and supervisory personnel and direct service providers (social workers).

**Judicial/Courts (n=14)**
We interviewed judges, commissioners, juvenile court administrators, and an ARY/CHINS facilitator for the courts. In most counties, judges and commissioners were the initial contact.

**Law Enforcement (n=13)**
Initial contacts were police chiefs and county sheriffs. In some counties we interviewed these individuals, and in other counties we were referred to others including police officers (community service officer), police captains or sergeants.

**Schools (n=14)**
We interviewed administrative personnel from educational service district programs, school district drug programs or other programs, school principals and vice principals, and an attendance officer.

**Sample Limitations**
The sample is a purposive sample and is not representative. The positions of people interviewed vary by county, in part reflecting the people who are knowledgeable or involved with the "Becca" Bill implementation, as well as reflecting the ability or willingness of initial contacts to take the time for the interview. For example, the police chiefs in more rural areas spoke with us but we had more difficulty finding an appropriate key informant for law enforcement who would speak with us in Seattle/King County area. As already noted, the school sample was affected by the timing of the interviews. Schools are most dramatically affected by the "Becca" Bill in terms of the truancy components of the legislation, and most of our respondents spoke to this aspect. However, school-based chemical dependency interventions for youth may have also been impacted by the implementation of the "Becca" Bill, but we were less successful in

making contact with staff involved in these types of programs. In addition, we interviewed one residential treatment agency in Skagit County that had several "Becca" admissions and was part of the treatment outcome evaluation for the "Becca" Bill. In general, depth within particular agency types was sacrificed in favor of breadth across agency types and regions.

We provide results by agency type for descriptive purposes. However, it should be remembered that the number of respondents for each type of agency is small and what may appear as large differences between agencies may be due to only a few people. Thus, any differences must be interpreted cautiously and as only suggestive.

# RESULTS

## I. IMPLEMENTATION OF THE "BECCA" BILL

The legislation had very different implications for the various systems. Table 3 presents some of the main changes legislated by the "Becca" Bill for each system. In terms of treatment systems, the Bill primarily addressed youth and parental consent issues around treatment admission. The workload for courts was increased due to its role in adjudicating truancy, ARY and CHINS petitions, ITA admissions, as well as contempt of court proceedings for noncompliance. A major impact of the legislation for law enforcement was its role in picking up youth on the street and transporting them to either their parents home and/or the secure Crisis Residential Centers (CRC). DCFS was impacted through their role in assisting parents or youth in filing CHINS petitions, providing family reconciliation services, and assisting parents in the application of ARY petitions. For shelters and other youth providers, one of the major implications of the Bill concerned requirements to report runaway youth and penalties for "harboring" known runaway youth. Schools were primarily impacted through the truancy component which mandated reporting on truancy petitions and taking parents and youth to court after a specified number of truant episodes.

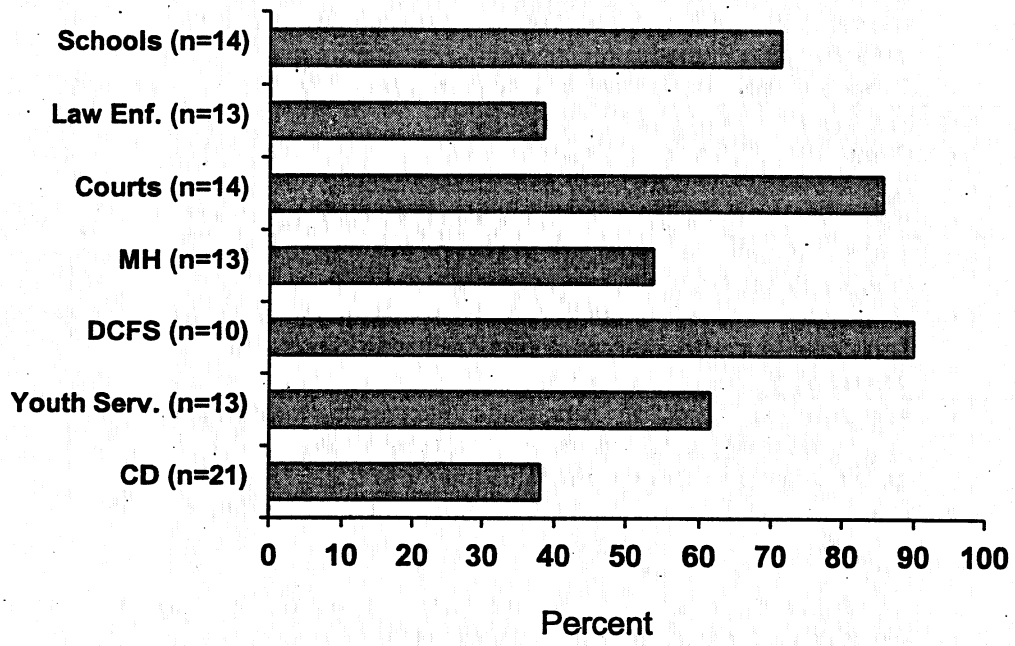
**Table 3: Procedural Changes Mandated by the "Becca" Bill by Type of Agency**

| Type of Agency | Highlight of Procedural Changes |
|---|---|
| **CD Treatment** | • Changed age of consent for outpatient treatment (from 14 to 13)<br>• Explicitly authorized parents to apply directly to residential treatment agencies for evaluation of child<br>• Established that youth could be admitted to residential treatment without their consent upon application of their parents[2]<br>• "Becca" Too allowed youth who met criteria for CHINS petition to be admitted to inpatient treatment without parent consent |
| **Youth Shelters** | • Established secure CRCs: assessment, crisis stabilization services and referrals, family reconciliation services and referrals, convening multi-disciplinary teams<br>• Changed reporting laws of runaway youth for shelters |
| **DCFS** | • Provide family reconciliation services<br>• Convene multidisciplinary teams<br>• Assist parents with filing ARY or CHINS petitions<br>• Assist youth with filing CHINS petitions, or file on behalf of youth |
| **MH treatment** | • Authorized parents to apply for admission to a mental health evaluation and treatment center<br>• Established process for admission of non-consenting youth upon application of parent (separate from Involuntary Treatment procedures). |
| **Judicial** | • Adjudicate ARY and CHINS petitions. Fact-finding hearing within 3 judicial days after filing, disposition hearing with 14 days after petition granted, and court review 3-months after disposition hearing[3]<br>• Adjudicate contempt of court proceedings when petitions not followed through<br>• Adjudicate truancy petitions<br>• Becca Too emphasis use of ITA process for youth with both Mental Health and Chemical Dependency problems |
| **Law Enforcement** | • Transport runaway youth to his/her parent's home/office, to another adult/shelter at parent's request, to CRCs<br>• Report to CRCs reason for bringing youth<br>• Report to CPS if suspected abuse/neglect |
| **Schools** | • Required school districts to create community truancy boards to recommend methods for improving school attendance<br>• Established truancy reporting requirements and upon a child's fifth unexcused absence in a month, or tenth in a year, the school district must file a truancy petition in juvenile court<br>• Required schools districts to document actions taken to comply with the truancy laws and report to OSPI<br>• Authorized school district official to make arrests, take into custody, and transport truants to parents, school or designated programs.<br>• "Becca" Too required school districts to report to parents referrals of youth to residential treatment agencies within two days |

## Changes Made by Agencies to Implement the "Becca" Bill

- **70% or more of DCFS, Courts, and school respondents reported changes were made to implement the Bill.**
- **Less than half of chemical dependency or law enforcement respondents indicated they had made changes.**

**Figure 1: Percent Reporting Operational/Procedural Changes in Response to the "Becca" Bill, By Type of Agency**




Respondents were asked whether their agency or department had made any operational or procedural changes in order to implement the legislation. As can be seen in Figure 1, nearly all of the DCFS respondents (91%, 10/11), and about three-quarters or more of judicial (86%, 12/14) and school respondents (71%, 10/14) reported changes whereas, a little over half of the mental health (54%, 7/13) and youth service respondents (62%, 8/13) reported changes. Furthermore, less than half of the law enforcement (39%, 5/13) and chemical dependency agency respondents (38%, 8/21) reported making changes.

It is not surprising that the majority of DCFS, courts, and schools reported having made changes to implement the Bill. However, in interpreting responses from other agencies, it is important to keep in mind the broader context. A key component of the legislation was the establishment of secure Crisis Residential Centers. At the time of the interviews, there were still no secure CRCs in operation. In fact, by June 30, 1997, only one secure CRC had opened, and it did not open until May, 1997. Law enforcement officers in particular noted the lack of CRCs, and the lack of resources allocated in the Bill for transporting youth, as an important reason no changes had been made. As one law enforcement respondent indicated,

> Frankly, because there are no secure facilities in which to place children, law enforcement is not going to out of its way to apprehend these kids or to pick them up knowing that the kids will be out the front door or wherever they're taken before the law enforcement can clear the parking lot. ... And cops just aren't

> gonna do that. Cops are real practical people and if they see that it has little ability to be effective, they just are not gonna do it.

Also, shortly after the Bill was enacted, the procedures for placing youth in mental health treatment without their consent were challenged and the case was heard by the state Supreme Court. While the case was pending, many mental health agencies stopped admitting youth without consent.

For chemical dependency treatment, the legislation in fact changed very little in terms of residential treatment admissions. Parents had always had the right to admit youth to treatment without their consent, although parents may not have been aware of that right. As was true before the legislation, agencies ultimately determine whether or not the youth is actually admitted to treatment based on an assessment of the youth's appropriateness for treatment, and whether their agency is able to meet the needs of the youth. The other changes affecting chemical dependency treatment agencies were from DASA. They required agencies to report all "Becca" admissions to DASA within 24 hours, and they also established that "Becca" youth be given priority for publicly funded treatment beds, in addition to youth from juvenile rehabilitation and pregnant teens. At the time of the key informant interviews, the number of residential "Becca" admissions across the state was modest, about 91. Should the number of "Becca" admissions increase, establishing "Becca" youth as treatment priorities may have more of an impact on residential treatment procedures. (The impact of the "Becca" Bill on treatment agencies is described in a later section.)

### Implementation Barriers

The different implications of the legislation across systems also came through in response to questions about the barriers agencies faced in implementing the Bill. We asked respondents what types of barriers they had faced in implementing the "Becca" Bill, and then asked about seven specific potential barriers that had been gleaned from sources such as meetings where the "Becca" Bill was discussed and newspaper reports on the "Becca" Bill. Each barrier was rated by respondents on a three-point scale to reflect how much of a problem it was for their agency from "not at all a problem" to "a major problem." The implementation barriers that were asked about were: confusion about the legislation, lack of financial resources to implement the Bill, increased staff workload, concern about violating rights of youth, concern that youth would stay away from social services, lack of shelters or other youth services, and lack of secure Crisis Residential Centers.

Because the Bill's implementation had different implications for different types of agencies, we looked at the barriers by type of agency. We also examined the differences by type of agency and region (eastern and western Washington). The sample size is too small to be able to detect statistically significant differences, particularly in the latter analysis. Also, there are differences in the job positions of respondents from eastern and western Washington. Thus, any differences should be interpreted cautiously. We focus on the results by agency type and highlight where responses appear to differ by region.

- **The three most important implementation barriers faced across agencies were:**
  - **Lack of youth shelters and other youth services**
  - **Lack of secure CRCs, and**
  - **Lack of financial resources allocated for implementation.**

**Table 4: Means for Implementation Barriers, by Agency Type**

| | CD n=21 | Youth Serv. n=13 | DCFS n=10 | MH n=13 | Court n=14 | Law Enf. n=13 | School n=14 | Row Avg n=98 |
|---|---|---|---|---|---|---|---|---|
| **Confusion** | .81 | • 1.38 | 1.10 | ♠ 1.62 | 1.14 | .33 | .64 | .99 |
| **Resources** | • 1.00 | ∇ 1.46 | • 1.60 | • 1.33 | ♠ 1.86 | 1.25 | ∇ 1.64 | • 1.42 |
| **Workload** | .38 | .31 | 1.20 | .62 | ∇ 1.79 | .85 | ♠ 1.71 | .94 |
| **Violate Rights** | .52 | 1.23 | .50 | • 1.39+ | .54 | .23 | .50 | .69 |
| **Soc. Serv.** | .30 | 1.15 | .40 | .85 | .33 | .39 | .46 | .54 |
| **Lack shelter** | ∇ 1.52 | ♠ 1.62 | ∇ 1.70 | ♠ 1.69 | • 1.69* | ∇ 1.33 | • 1.43 | ♠ 1.56 |
| **CRC** | ♠ 1.65 | .92 | ♠ 1.80 | ∇ 1.54 | • 1.62* | ♠ 1.83 | • 1.46 | ♠ 1.54 |
| **COL. AVG:** | .87 | 1.15 | 1.19 | 1.28 | 1.28 | .87 | 1.11 | |

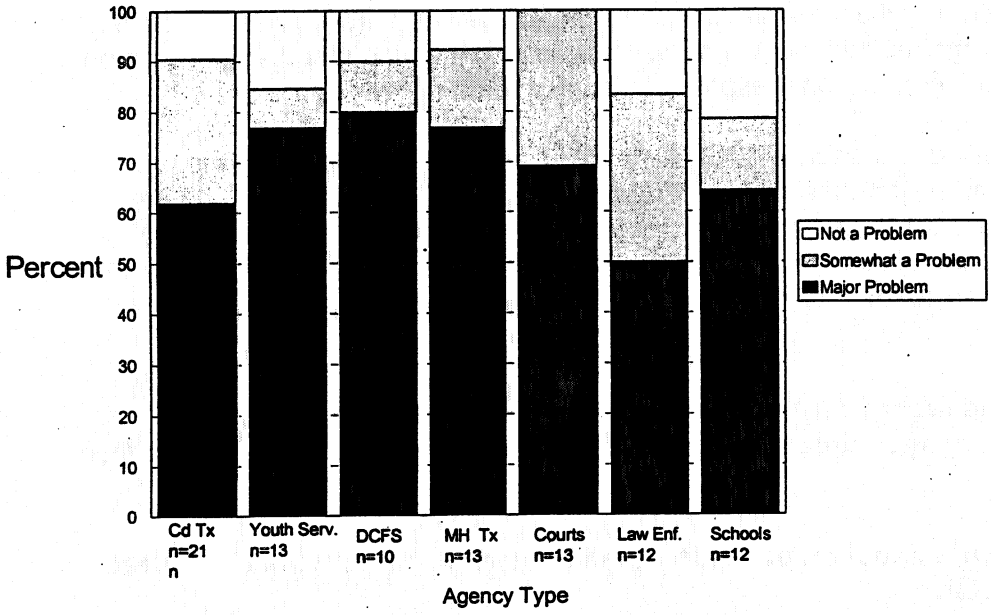
♠ = Highest ranked barrier
∇= 2nd highest ranked barrier
• = 3rd highest ranked barrier

Table 4 presents the average ratings within agency type for each barrier (ratings from 0, "not at all a problem" to 2, "a major problem"). Different symbols are used to indicate whether the barrier was rated the first, second, or third highest in average importance within each type of agency. As shown in the table, lack of shelters/ youth services was ranked as the first or second highest barrier for all agency types except courts and schools, and lack of resources was ranked third (with the exception of youth service agencies).

Across all respondents, the average number of barriers indicated as somewhat of a problem or a major problem was 4.7 (out of 7). The average number of major barriers reported was 3.9. There were apparent differences between agency types in the perceived importance of implementation barriers. Figures 2 to 8 present the responses by agency type.

- **70% or more of Youth Service, DCFS, and mental health respondents viewed the lack of youth shelters as a major problem.**

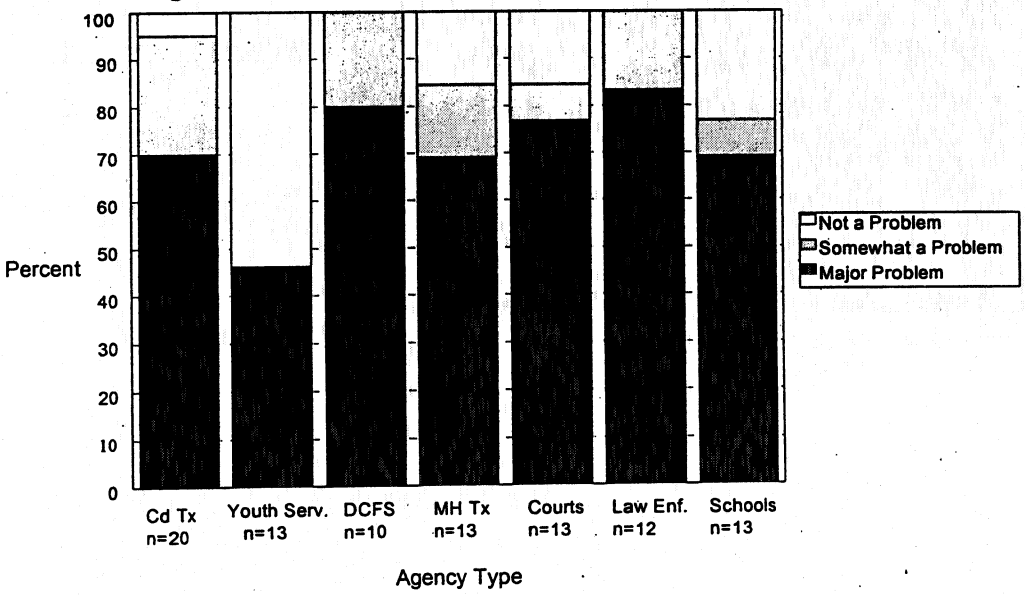
**Figure 2: Lack of Youth Shelters/Other Services (n=98)**




Lack of shelters and other youth services was seen as a major implementation barrier by the majority of respondents and at least somewhat of a problem by nearly all respondents. All of youth service respondents in western Washington, and none in eastern Washington, saw this as a major implementation barrier (not shown). However, only three youth service agencies from eastern Washington were interviewed.

- **80% or more of all respondents, except those representing youth shelters/other services and schools, viewed the lack of secure CRCs as somewhat of a problem or a major problem.**

**Figure 3: Lack of Secure Crisis Residential Centers**



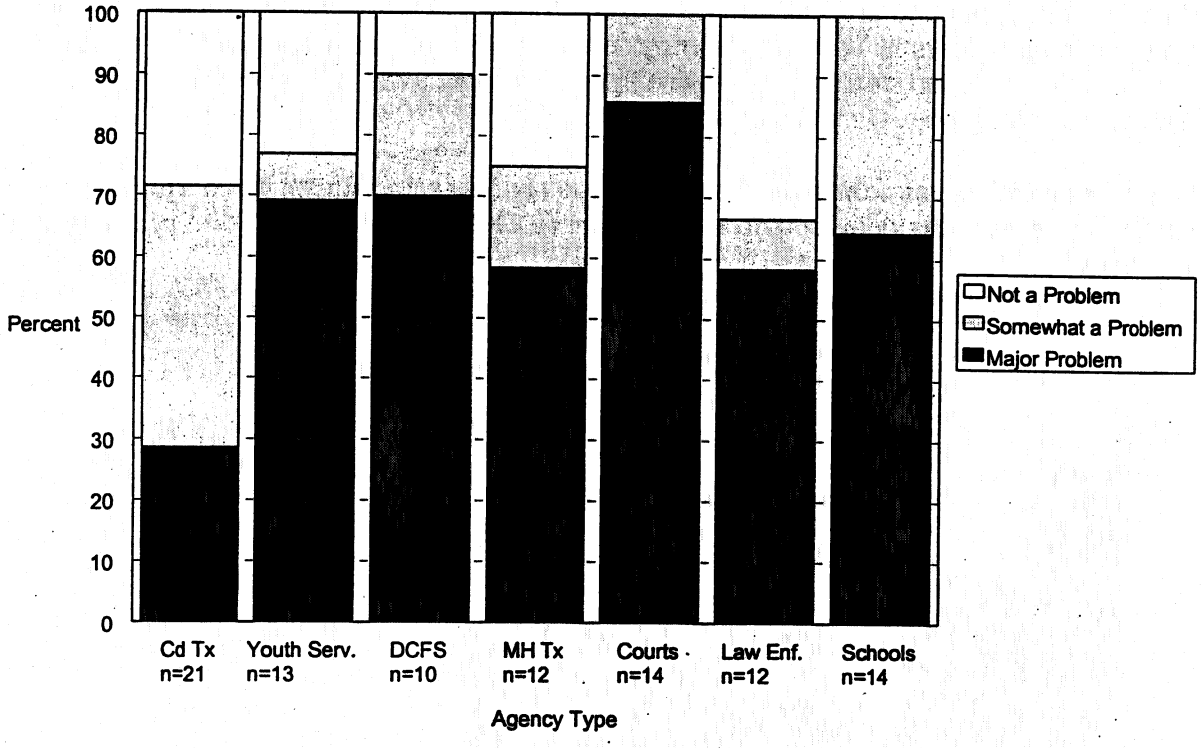
All of the law enforcement, DCFS, and the chemical dependency agency respondents (with the exception of one person) viewed the lack of secure CRCs as at least somewhat of a problem. Youth service agencies, however, were nearly evenly divided between viewing lack of secure CRCs as either not a problem (54%, 7/13) or a major problem (46%, 6/13), with no one in the middle. This dichotomy may reflect the sentiment among some youth advocates that placing youth in locked facilities against their will is not the answer and thus the fact that there are no secure CRCs is not a problem. As one respondent from a youth shelter said:

> I want to quit calling it a secure CRC, let's call it a jail and that's what it is. A juvenile jail, runaway jail, basically... Probably about 13% of the kids that we deal with, need to, for their own protection, need to be maintained in a secure setting. But, not all 100% of them. And the way the Bill is written now, all 100% would be subjected to it if there's a secure CRC, ...which is gonna embitter and alienate the kids.

- **Well over 50% of the respondents from all agency types, with the exception of chemical dependency agencies, saw lack of financial resources for implementation as a major barrier.**

- **All of the judicial and school respondents perceived lack of resources as at least somewhat of a barrier.**

**Figure 4: Financial Resources**



For courts and schools, lack of resources for implementation received the highest overall ranking. As articulated by a school respondent:

> I don't think that the people that decided this was a good piece of legislation really thought about how a school system could implement it. And there was little thought or consideration given to having technology in place prior to requiring people to do this and that it is not funded by the state. It was one more thing that the state imposed upon districts without any funding to go with it and said, you must do it and there's no option to gear up for it and no money to go with it.

Similarly, a court respondent said, speaking particularly about the truancy component:

> The biggest barrier that we've had is finances because this was an unfunded mandate. ...it was placed in the superior court, in with the juvenile division. But our court was already pretty overcrowded in terms of offender matters and dependency matters as it was. And so to add another layer on top of that was extremely burdensome for us but we managed it by getting people to volunteer to provide the services.

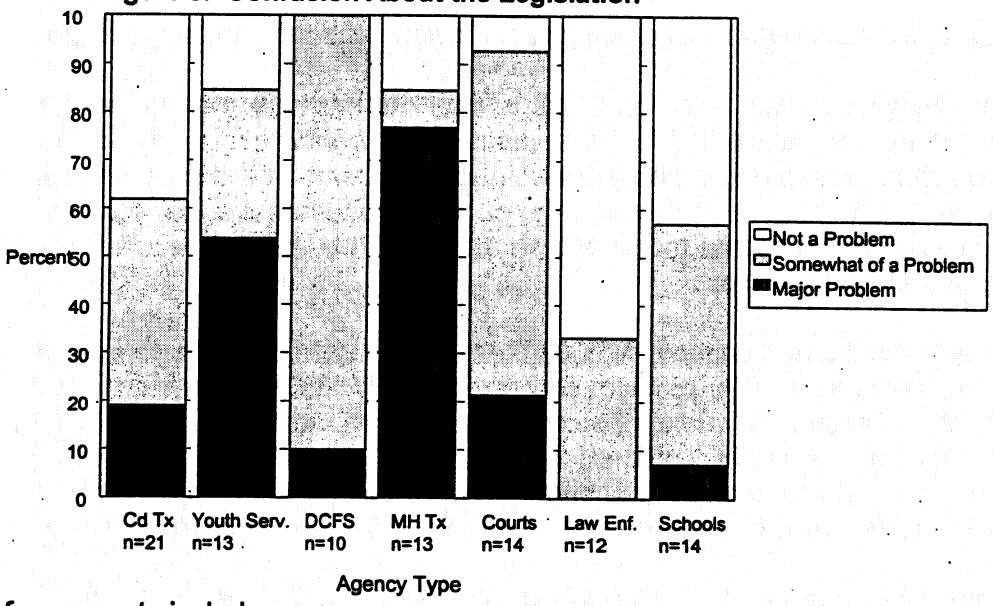
Among mental health respondents, 83% of those from eastern Washington saw the lack of financial resources as a major problem compared to only 33% from western Washington. Similarly, 83% of eastern Washington school respondents rated lack of financial resources as at least somewhat of a problem compared to 50% from western Washington (not shown). Although school districts in more rural areas may have fewer students and thus fewer truancy petitions to file, they also have fewer resources. For example, one school respondent said:

> I think the idea and the rational is good. The problem I see is just the trying to get the funds to implement it effectively. You know, we're a small district, wear a lot of hats and it's real hard to sometimes do that.

- **Over half of respondents in all types of agencies, except law enforcement, viewed confusion about the legislation as a barrier to implementation. All of the respondents from DCFS saw confusion over the legislation as at least somewhat a problem.**

- **Confusion about the legislation was seen as a major implementation barrier by over half of the respondents from youth service agencies and mental health treatment agencies.**

**Figure 5: Confusion About the Legislation**




Examples of comments include:

> Being able to understand that process and how you go about doing that and what avenue you go as a parent. I think there's a lot of confusion about, you know, do I do this CHINS thing or do I do this Youth At Risk or do I take them to an inpatient setting do I take them to a locked facility. What is it that I'm supposed to do because parents really need to understand what their rights are with the "Becca" Bill. It's not an invitation to put your kid in a locked facility, and there's that misconception out there, too.
> *CD Respondent*

> I think it's very difficult for people to figure out what to do with this and so I think that that's definitely a weakness in that it's confusing for service providers in understanding exactly what they need to do and how it needs to work and what's the purpose of it.
> *Youth Service Respondent*

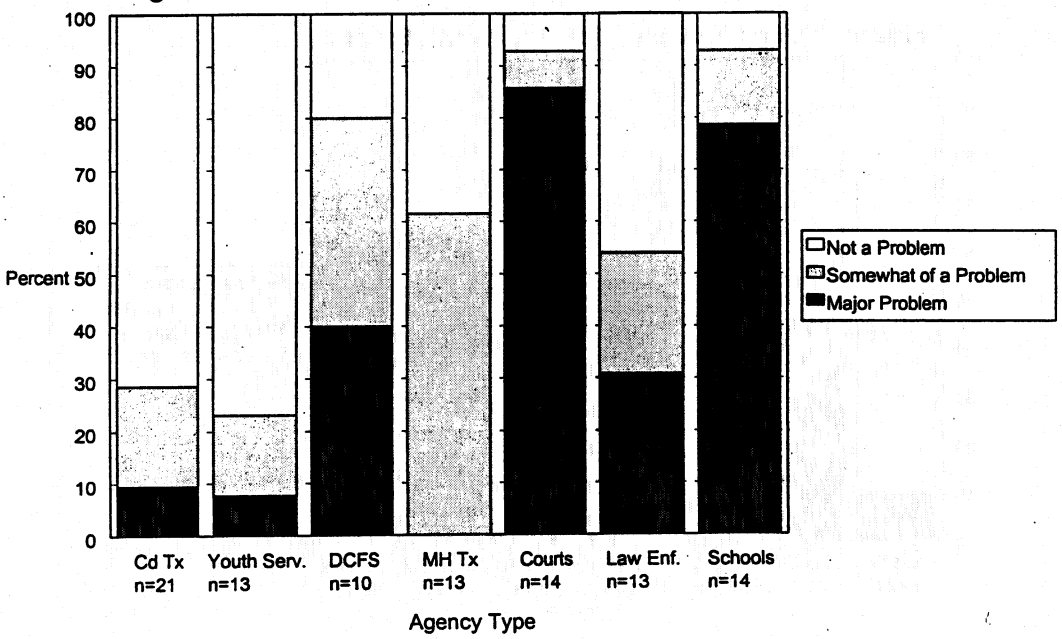
> It was so vague in terms of how it could be implemented and the confusion over the legal authorities involved and the fact that everybody recognized that the parents should have primary legal responsibilities for their child, but if the child's out of control how do you implement it.
> *Mental Health Respondent*

The pending state Supreme Court case most likely contributed to the confusion for mental health agencies. For shelters and youth advocates, the language of the law concerning the conditions under which reporting of runaway youth's was required by service providers was confusing. This, combined with the fact that many youth advocates believed reporting on runaway youth might result in the youth going more underground, was a substantial implementation barrier.

Among respondents from schools, all of those from eastern Washington saw confusion as at least somewhat of a barrier compared to only 25% of those from western Washington (not shown). However, although a substantial percentage of respondents found confusion about the legislation to be a barrier, other barriers ranked higher.

- **86% of court, and 79% of school respondents reported increased workload attributed to the "Becca" Bill as a major barrier.**

**Figure 6: Additional Workload**



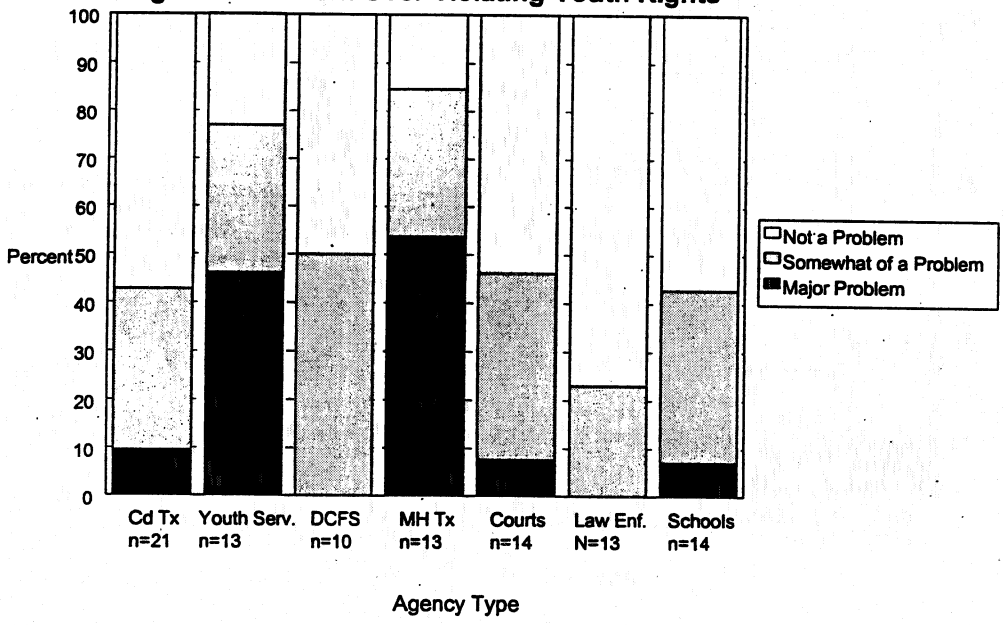

The increased workload for the court is primarily a function of processing truancy, ARY, and CHINS petitions (with truancy petitions being a particularly heavy load for some courts), whereas for schools it is tracking and reporting truancy, as well as filing truancy petitions. One respondent from the court said:

> It's wearing me out. ...(It is very) time consuming. I was working three or four nights a week from September through February until I could get my truancy commissioner trained. I've continued on supervising and sitting in and working with groups and educating and cheerleading and supporting and trying to get things moving and keep people going on this thing.

In contrast, only about a quarter of respondents from chemical dependency agencies (29%) and youth service agencies (23%) reported that increased workload was a barrier. In eastern Washington, 50% of the law enforcement respondents, compared to 14% of law enforcement respondents in western Washington viewed the additional workload as a major barrier (not shown). This is most likely due to greater travel distances required to transport youth.

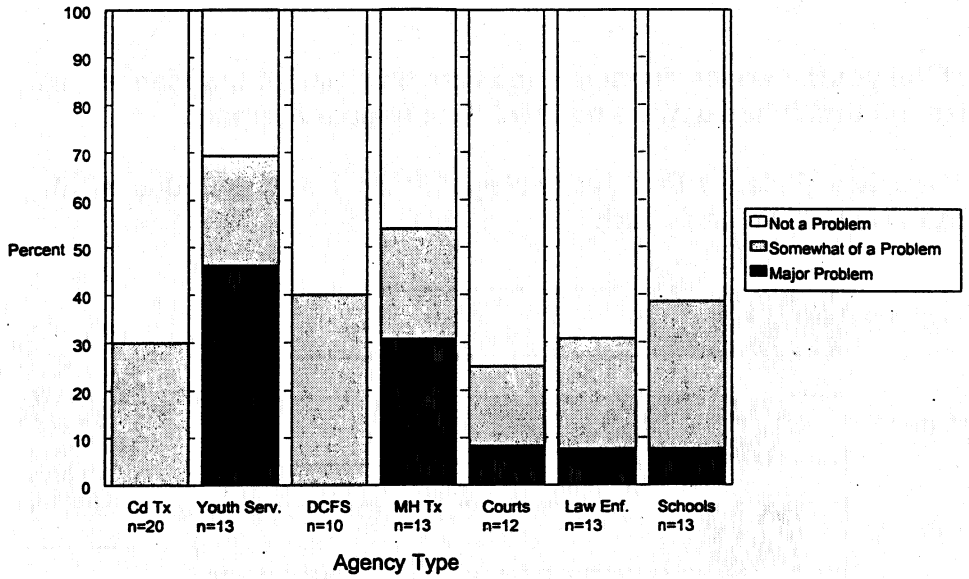
- **Concern about violating youth rights and concern that the effect of the Bill would be for youth to stay away from social services agencies was a major problem only for youth service and mental health agencies.**
  - **About 50% of mental health and youth service agency respondents reported that concern over violating youth rights was a major implementation barrier, compared to about 10 % of chemical dependency treatment and judicial respondents. No DCFS or law enforcement respondents saw this as a major implementation barrier.**

**Figure 7: Concern Over Violating Youth Rights**



- **About 70% of youth service and 50% of mental health respondents viewed concern over youth staying away from social services due to the "Becca" Bill as an implementation barrier compared to 20-30% of respondents from other types of agencies.**

**Figure 8 Concern: Youth Will Stay Away from Social Services**




The responses to the two items, concern over violating youth rights and concern that youth will stay away from social services, had similar response patterns. Mental health and youth service agencies were more likely to feel that concern over violating youth rights, and concern that the Bill would result in youth staying away from services, was a major barrier than were respondents from other types of agencies. Again, not surprising given the state Supreme Court case, all but two mental health respondents saw concern over violating youth rights as a problem. In western Washington, 80% of mental health respondents, compared to 17% of those in eastern Washington, saw concern over violating youth rights as a major barrier.

Addressing the issue of whether the Bill would keep youth from services, a youth service respondent said:

> That's been a terrible problem, not only has it been a fear but its been an actuality. The year before the "Becca" Bill we had a 102 youth come through placement, most of whom were reunited with their parents. The following year we had half that, just half, 60. Our phones went dead. Kids were absolutely undercover.

No eastern Washington respondents from the judicial system, youth service agencies, or mental health were concerned that youth stay away from social services or saw it as an implementation barrier, whereas 43% of judicial respondents, 57% of mental health respondents and all of the respondents from youth service agencies in western Washington viewed it at least as somewhat of a problem (not shown).

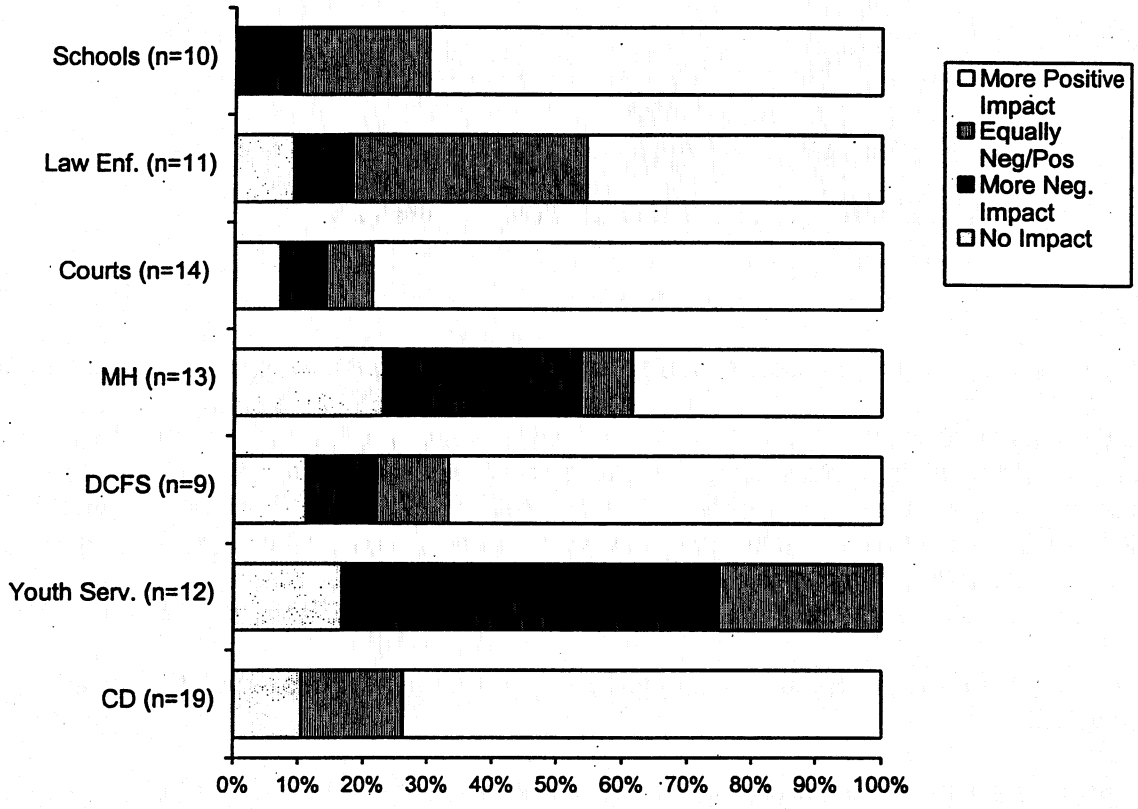
# II. Perceived Impact of the "Becca" Bill

## Impact of the Bill on Youth and Parents

- **Over two-thirds of respondents from CD treatment agencies, DCFS, the judicial system and schools felt the Bill had a more positive than negative impact on runaway youth.**

- **None of the youth service agencies and less than half of the mental health treatment agencies felt that it had a more positive than negative impact.**

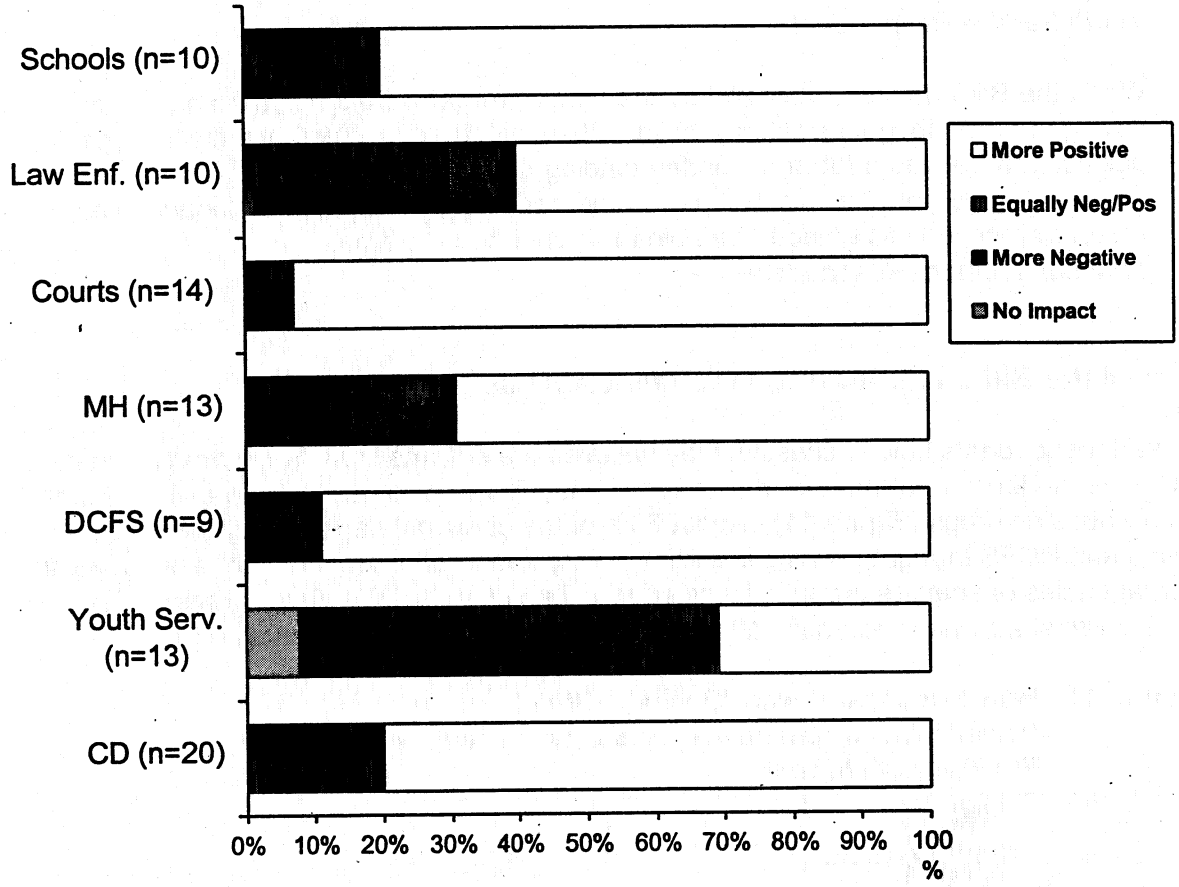
**Figure 9: Perceived Relative Positive to Negative Impact of the "Becca" Bill on Runaway/Homeless Youth**




We asked respondents whether they felt that overall the "Becca" Bill had had more of a positive impact, more of a negative impact, or no impact on runaway/homeless youth and on parents of runaway/homeless youth. As shown in Figure 9, almost all respondents felt that it had at least some impact on runaway adolescents. The majority of respondents from CD treatment agencies (74%), DCFS (67%), the judicial system (79%) and schools (70%) viewed the Bill as having had a more positive than negative impact on runaway adolescents, whereas none of the youth service agencies and less than half of the mental health treatment agencies (39%) felt that it had a more positive than negative impact. About equal proportions of law enforcement respondents believed that the legislation had more of a positive impact (46%, 5/11) as believed it had a neutral impact (equally positive to negative, 36%, 4/11).

- **With the exception of youth service agencies, the majority of respondents felt that the Bill had had more positive than negative impact on parents.**

**Figure 10: Perceived Relative Positive to Negative Impact of "Becca" Bill on Parents of Runaway/Homeless Youth**




Overall, most respondents felt the Bill had a more positive than negative impact on parents. Only one respondent felt that the Bill had had no impact on parents of runaway youth. About 60% of the youth service respondents, and 30% of law enforcement respondents felt that it had had more negative than positive impact.

The main negative impact on parents discussed by respondents was that the Bill had misled parents in terms of what the legislation actually does, which resulted in a great deal of frustration and anger. For some parents there was the belief they could call law officers and get their child locked up, for others it was the belief that the Bill provided more family support, and others believed that it would guarantee their child an immediate placement in treatment.

Examples of comments include:

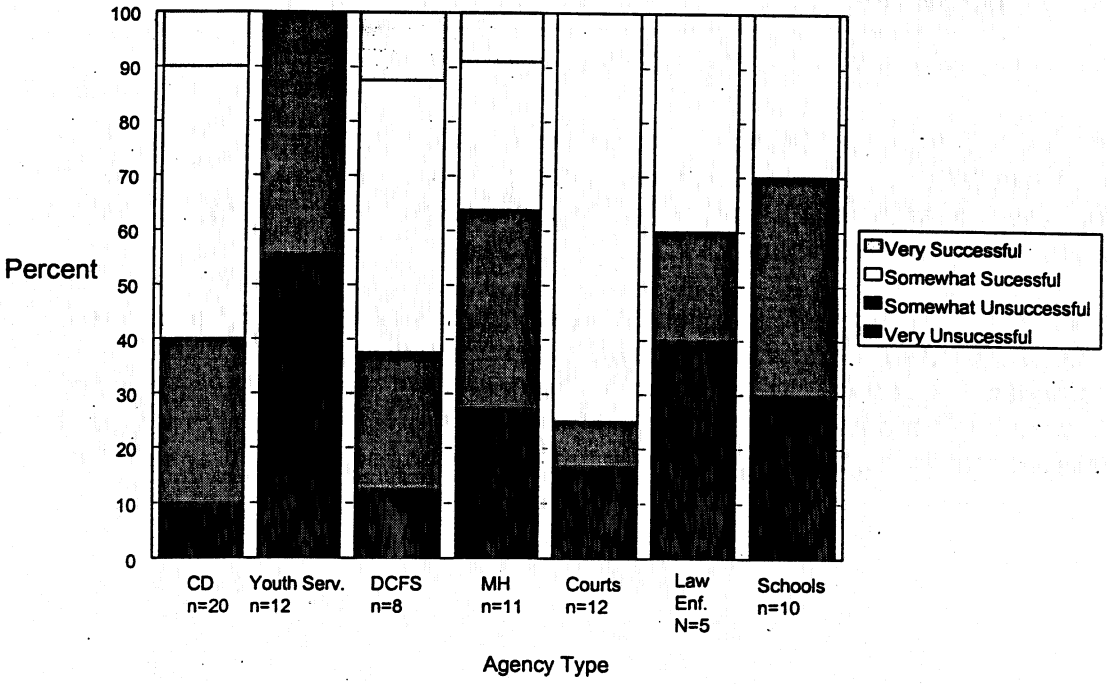
> Negative because they have this illusion that they had something, that society did something for them... And people thought that they had something here, and then when they started gauging it, they find that it's all smoke, there's nothing really there of substance.
> *Youth Service Respondent*

> When the Bill was first publicized by the media we got a lot of calls from parents saying, I want to go arrest my child. Well, when we told them that wasn't possible, there was a lot of misunderstanding about the "Becca" Bill. There was some frustration on the parents' part in the beginning because they thought that law enforcement was going to be able to solve their problems.
> *Law Enforcement Respondent*

## Impact of the Bill on Improving Treatment Access

We asked respondents how successful they believed the Bill was in helping parents obtain chemical dependency treatment for their adolescent children who have run away from home and were abusing drugs (Figure 11). About 60% of the chemical dependency treatment agencies and DCFS thought it was somewhat to very successful, whereas none of the youth service agencies or shelters thought it was successful. Most judicial respondents (75%) thought it was somewhat successful although none thought it was very successful.

**Figure 11: How Successful was "Becca" Bill in Helping Parents Get Chemical Dependency Treatment For Their Children?**



## Impact of "Becca" Admissions on Chemical Dependency Treatment Agencies

We were interested in what kind of impact, if any, admission of youth into chemical dependency treatment under the "Becca" Bill was having on residential chemical dependency treatment agencies. We discussed whether "Becca" youth and their families presented different challenges for the treatment agencies, and whether the admission of "Becca" youth had had any effect on the treatment milieu. The treatment agencies varied in the types of services that they provided. Of the 21 respondents from chemical dependency treatment agencies, 18 provided chemical dependency treatment services.[4] Of these, 15 reported that they had had referrals for evaluation or treatment of "Becca" youth, and all but two of these 15 had admitted "Becca" youth. (The remaining questions in this section were only addressed by these 13 respondents).

**How are "Becca" youth and their families different from others in adolescent treatment?**
We asked whether respondents found "Becca" youth to be different from other adolescents in their treatment program. Only two (17%) respondents felt that they were different, indicating that they are "more out of control, resistant, oppositional, angrier" and that their condition and needs are more critical.

However, about half (46%) of the respondents felt that the families of "Becca" youth presented special challenges. A couple of respondents indicated that the parents are more demanding of the treatment of agencies, but are not willing or able to do their part in addressing the issues. Many of the parents were said to have drug or alcohol problems themselves and live unstable lives. Another respondent indicated that more time is needed for some of these families to help improve their communication skills and address other service needs if the youth is returning home.

On the other hand, a few respondents indicated that "Becca" families are easier to work with and are more involved in their children getting help, noting that these parents have to put in a lot of time and effort to complete the petition process.

**Has the admission of "Becca" youth affected treatment at the agency?**
Only three (23%) of the respondents felt that admitting these youth had had any effect on the treatment milieu of their agency. Some respondents indicated that they had not yet admitted enough "Becca" youth for it to have had much of an impact and, as noted above, others felt that once admitted to treatment, "Becca" youth were no different from the other youth admitted.

Among the respondents who did feel there had been an impact, one indicated it had a negative impact, one a positive impact, and the third was neutral. One respondent said that it has affected trust issues within treatment groups, because "Becca" youth feel that they have to be there and thus do not have the internal motivation and that "they're not as open-minded. Not as willing. And they're not as honest." A second respondent indicated that it has in fact strengthened their family treatment program. A third respondent said that youth who were not informed about the "Becca" Bill became informed of it and how it might impact them.

The "Becca" Bill was reported to have affected treatment availability in about a third (38%) of the agencies and that it resulted in delays in non-"Becca" youth being admitted to treatment. A

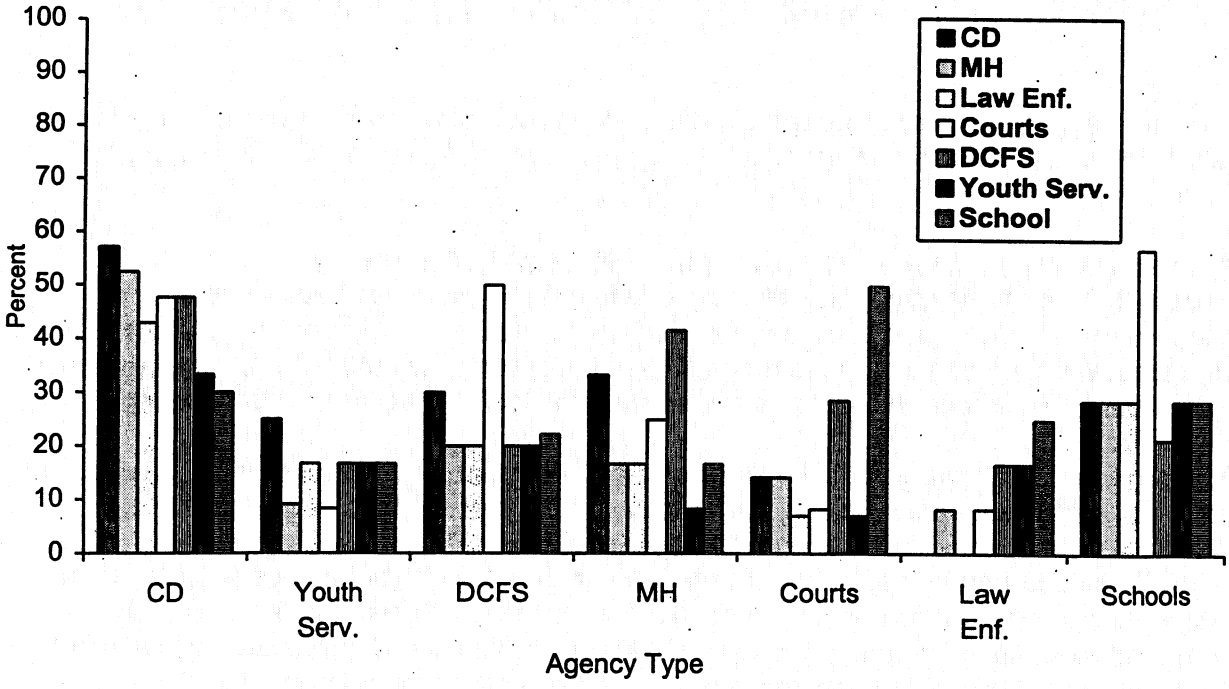
couple of respondents indicated that it made access easier for publicly funded "Becca" youth because they are given priority, whereas others said that it is putting a strain on available resources. One respondent indicated that it was increasing the number of youth in outpatient treatment groups. The number of non-"Becca" youth who were delayed admittance was estimated by all but one of the agencies to be under 10 youth, with eight agencies reporting that there have not been any admission delays.

## Impact of the Bill on the Development of Interagency Linkages

The implementation of the "Becca" Bill had the potential for increasing interaction and coordination among different systems. The "Becca" Bill included provisions for voluntary multi-disciplinary teams to evaluate the youth and determine their need for services. Through the ARY and CHINS petitions, and truancy component, new court procedures were created that increased the interaction of school and DCFS staff with the judicial systems. Police, with increased authority to pick up runaway youth for whom an ARY petition had been filed, would potentially have more interaction with DCFS, chemical dependency and mental health treatment agencies, and possibly youth service agencies.

We asked respondents whether, as a result of the "Becca" Bill, their agency had developed new or stronger linkages with any of the other systems. Figures 12 presents the results.

**Figure 12: Percent Reporting New or Stronger Linkages, with Specific Types of Agencies, By Type of Respondent**



Compared to respondents from other agencies, respondents from chemical dependency agencies reported a higher percentage of new or stronger linkages to other agencies, with an average of 3.4 new or stronger interagency linkages, whereas youth services and law enforcement reported the fewest number of such linkages (mean number = 1.2 and .69 respectively). However, the percentage of respondents from other agencies reporting new or stronger linkages with chemical dependency treatment agencies was lower. Roughly 30% of youth services, DCFS, mental health, and school respondents reported new or stronger linkages with CD agencies. No law enforcement respondents, and less than 15% of judicial respondents reported new or stronger linkages with CD agencies whereas over 40% of CD treatment agency respondents reported new or stronger linkages with law enforcement and judicial systems. This discrepancy in reporting could be due to differential knowledge of linkages by the specific interview respondents in the different systems. The sample is too small, and the question to broad, to draw conclusions about discrepant reports.

There appears to have been a substantial change in relationship development between the judicial system and DCFS, CD treatment, and schools. In fact, for both DCFS and schools, the most marked new or stronger relationships were with the judicial system. Also, over 50% of the judicial system respondents reported new or stronger linkages with schools, and about 30% reported new or stronger linkages with DCFS. Thus, it appears that the various petition processes have resulted in the development of intersystem linkages between the judicial system and social and educational services.

We also asked respondents whether there were relationships they thought would be helpful for their agency to develop to implement the "Becca" Bill. As shown in Table 5, over half of the respondents from all agencies except law enforcement and youth services felt that developing relationships with other agencies would be helpful. Nearly 86% of the DCFS respondents, three-quarters of chemical dependency respondents, and two-thirds of court respondents felt that development of interagency relationships would be helpful. It should be noted that this question was not asked of the first 20 participants (after which the interview was revised) and thus there are responses for only 78 out of 98 interview participants.

**Table 5: Percent of Respondents Who Believed the Development of Inter-Agency Relationships Would be Helpful**

| | CD Tx n=20 | Youth Services n=8 | DCFS n=7 | MH n=13 | Courts n=12 | Law Enf. n=6 | Schools n=12 | Overall n=78 |
|---|---|---|---|---|---|---|---|---|
| % Yes | 75.0 | 37.5 | 85.7 | 53.8 | 66.7 | 33.3 | 58.3 | 61.5% |

We examined the types of agency relationships that were desired by type of agency, however, the number of respondents for any given type of agency was small and no consistent pattern emerged. Most respondents indicated that they wanted to develop relationships with the courts (14%, 11/78), with about a third of the school respondents (4/12) indicating that this would be helpful, and one or two respondents from all other types of agencies except youth services indicating that this would be helpful. About 10% (8/78) of respondents wanted to develop relationships with CD treatment agencies. A third of the court respondents (4/12) indicated that they thought relationships with CD treatment agencies would be helpful, with about 15% of DCFS (1/7) and Mental Health (2/13) respondents indicating that developing these relationships would be helpful.

Thus, although almost everyone thought some new relationships would be helpful, there was not consistency within type of agency for what relationships would be most helpful. This may reflect the different structures that were already in place within different communities. Also, the questions addressed the development of interagency relationships for the implementation of the "Becca" Bill, and not the importance of developing these relationships for other purposes. As will be discussed later, there were a number of respondents across types of agencies who indicated that there is a need to improve coordination and interagency linkages to better serve youth.

## III. PERCEIVED STRENGTHS AND WEAKNESSES OF THE BILL

### Perceptions of the Major Strengths of the Bill

We asked respondents what they perceived as the major strengths of the legislation. Table 6 presents the main response categories of responses, and examples of the types of responses in each category, based on content coding of the interview transcripts.

**Table 6: Perceptions of the Major Strengths of the Bill**

| Key Strengths Mentioned | % | n=95 |
|---|---|---|
| **Positive impact on parents:** Increases parental control/authority, helps parents get services for children, provides parents support, helps families addresses problems, gives hope | 51.6 | 49 |
| **Positive impact on youth:** Helps youth get treatment, helps youth get other types of assistance | 27.6 | 26 |
| **Brought attention to important issues:** Increased awareness of runaway issues, truancy issues, need for juvenile justice reform, need for increased adolescent chemical dependency treatment | 27.6 | 26 |
| **Truancy Component:** Reduced truancy, financial benefits to schools, creates process to address truancy, holds youth/parents accountable for truancy | 17.9 | 17 |
| **ARY/CHINS Petition Processes:** Provides new tools for parents | 6.3 | 6 |
| **Interagency Linkages** | 4.2 | 4 |

*(Note: The table reflects the number of people giving a certain type of response. Multiple responses were possible so columns do not add up to 100 percent.)*

**Positive Effects on Parents and Families**

The majority of respondents indicated the major strength was the positive impact on parents. The types of positive impact included empowering parents and helping parents increase or regain authority over their children, helping parents get needed services for their children, and giving parents hope.

> I think the main strength is that it's shifting the balance now back from total youth unaccountability--in other words, pretty much free reign to do what they want because they have so many rights--back to giving some parents, certainly those who feel the need to actually be parents, the ability to get some help for their kids that at least in recent years, they haven't been able to do. I think that's the biggest impact. That it's giving some hope to parents who care about their kids to actually get them some help.
> *CD respondent*

> I think in the truancy portion, what I see having happened here was dignity given to parenting, even to the crummiest parents. Sitting there in court, they were dignified, they were respected. Students were encouraged in respecting the role of the parents and it was instructional for parents. Many of whom just couldn't fathom what their job was. And so they were taught right there in court.
> *School Respondent*

Some respondents emphasized that in addition to giving parents more control, it was important that the Bill also gave them responsibility or accountability.

> We're moving into asking parents to be more responsible for care of their children. Probably the best thing that the Bill has to offer is that it's giving parents increased rights and responsibility.
> *Mental Health Respondent*

> I think it's (*ARY petition)* an excellent process when it's a parent initiated petition. And it puts the responsibility on the parent that, yes, you're asking for our help but it's still your problem. You need to work with us on it. The concept of that is very good.
> *Court Respondent*

**Positive Impact on Youth**

The primary positive impacts of the Bill on youth that were mentioned were that it has helped increase the safety of youth on the streets, helped youth get into treatment, helped youth access family services, and helped youth get themselves under control.

> I see the strength is that there is some positive benefit to taking steps to ensure that the At Risk Youth that are contacted out there are directed towards the system where they can be referred for treatment, counseling, and so on.
> *Law Enforcement Respondent*

> I think first and foremost is the fact that a kid who is perceived to be out of control can be given a space and in time to get back in control and no matter how short, that's still something. That kind of thing can be stopped, at least

momentarily. For them to say 'whoa, is this really what I want to do?' That I think, is really the most important.
*CD Respondent*

A few respondents also indicated that the Bill was reaching different populations of youth.

The kids I'm familiar (*with who are*) using this Bill are kids who are drug affected, whose moms used while they were pregnant with them and there's neurological damage and they just cannot be contained. Now I bet the Bill wasn't meant for these kids. I think the legislators probably thought it was kids who just wanted to use pot and not go to school, but it's catching the group of kids that need lots of structure around them.
*Mental Health Respondent*

**Increased Awareness of Issues**

A second perceived strength of the Bill was that it increased awareness of important social issues and began a needed dialogue. Issues that were mentioned included the needs of runaway/homeless youth, the need for more treatment services, and the need to reform the juvenile justice act.

Well I think a definite positive effect is that it has gotten people in the community who work in the system--between case workers and court staff and judges and legislators--it's really developed a huge awareness of the numbers of families that are having problems raising their kids, for whatever reason, or feel that they need help from the system in dealing with that.
*Court Respondent*

I think one of the big strengths is that it focused attention on the issues of runaway and homeless youth ... I think it was an acknowledged fact that there are kids who are in a position of danger that we as a system aren't adequately dealing with. I don't support the specific remedies that are in there but I think it was asking the question and bringing some attention to the issue in a way that hadn't been done before.
*Youth Service Respondent*

Well, I think the main contribution the Bill has made, even though it's raised a lot of frustration because of false expectations, is that it has highlighted and focused attention on the needed reforms in the juvenile justice system.
*Law Enforcement Respondent*

The one positive effect could very well be an articulation of the need for increased substance abuse services for youth 'cause there seems to be a very limited capacity for youth to receive substance abuse services.
*Mental Health Respondent*

I think that we're beginning to recognize that there are some youths currently on our streets who are so significantly at risk they cannot make good choices and might need mental health services. I think the mental health piece is the big one for me because I think that the kids that we see that are the most difficult to engage are the ones that really are psychiatrically impaired. ... the mental health system hasn't opened up beds or the ability to access those beds.
*Youth Service Respondent*

**Truancy**

Particularly for school respondents, but also for some court respondents, the truancy component of the Bill was seen as one of the central components of the Bill and the component that was most effective. The positive strengths cited of the truancy component included that it helped with early identification of families in trouble, that it helped keep kids in school, and it increased both parent and youth accountability.

The main strength on the truancy portion is that it informed the children and parents of the legal obligation to go to school and create a vehicle so that interested parties could address the reasons for truancy.
*Court Respondent*

I think the main strengths, one, with truancy, is, hopefully, we will get more consistent application across the state with keeping kids in school and focusing on the truancy issue at a very young age when those signs start showing up. Not so much the 15, 16 year olds but down in the 12 and 13 year olds that are having attendance problems. I think that we're going to see over the next several years a real positive impact with school participation.
*Court Respondent*

Well number one, kids are going back to school. And I think as a piece of that is, if kids are in school then they're not out on the streets involved in crime and other kinds of things. So I don't have any statistics in terms of crime rates decreasing, but I honestly know that it has decreased when those kids are in school.
*School Respondent*

It's putting a strong emphasis on intervening with kids early... truancy may come up as one of the first presenting problems, rather than waiting for things to get worse, trying to intervene with it then. Second, how the court and schools are working together. And then the third area, I guess, would be the recognition that, involving parents is a key.
*School Respondent*

Well, I'm very fond of the truancy aspects of the Bill. I find that I can work with a family quite easily once I find the family, and I find more families in truancy cases than I do anyplace else.
*DCFS Respondents*

**ARY and CHINS Petition Process**

A few respondents felt that the ARY and CHINS petitions were having a positive impact on parents and families.

> Again I gotta go back to the CHINS petitions, the at risk petitions and the truancy petitions. Number one, they're identifying at-risk kids. And two, they're action oriented. That something takes place, there's intervention, there's action that takes place with them. It's not just kids being identified.
> *CD Respondent*

> I think the main strength is the ability to take them to court. File a petition and have a court deal with the situation. That's a strength.
> *Law Enforcement Respondent.*

> Well I think for some youngsters, it has allowed them to identify family circumstances that are supportive to them and for some parents it has allowed them to identify youth who are not responsive to parental direction, and it has allowed for oversight of that by the juvenile court and some monitoring of it. I think that has been helpful.
> *Mental Health Respondent*

**Interagency Linkages**

Finally, another benefit of the Bill mentioned by a few respondents was that it facilitated different systems working together, and it changed how programs were working with youth to be more effective.

> I think it's forcing providers who have been in business for a long time to look at providing services differently. I don't think that's wrong. I don't think we can do the same thing we did 20 years ago. Nor do I think that we need to create some fancy, high-tech. I think we need to get back to the basics and we need to individualize it for the counties in the region. What works for Seattle does not work for us. Or vice-versa. I mean, we're dealing with a different population, a different type. And they may fit under the same runaway category, they're different, they're different youth. There needs are a little bit different.
> *Youth Service Provider*

> One of the main strengths is that it's provided the impetus or incentive for the Department of Social and Health Services to actively do family reconciliation, which I don't think they were doing before. They've had to focus some resources on that. I think that they're being a lot more creative and energetic about it than they were in the past and so a lot of these situations are getting resolved.
> *Court Respondent*

## Perceived Weaknesses of the "Becca" Bill

Respondents were also asked their overall assessment of the main weaknesses of the Bill. As shown in Table 7, many of the weaknesses identified parallel the barriers discussed earlier. The two most frequently cited weaknesses of the legislation were that it was confusing and thus

difficult to implement, and that it did not provide the resources to either implement the legislation or to provide the services for youth who were the focus of the legislation. The major weaknesses identified will be briefly outlined, with attention drawn to points made that have not already been discussed.

**Table 7: Key Weaknesses of Bill**

| Key Weaknesses Mentioned | % | n=98 |
|---|---|---|
| **Bill Confusing, ambiguous, implementation unclear:** Misinformation, lack of technical assistance, lack of standard implementation | 25.5 | 25 |
| **Unfunded mandates** | 23.5 | 23 |
| **Parent/Family Issues:** increased parent frustration, puts courts in between parents and children, procedures too complex | 19.4 | 19 |
| **Youth Issues:** Bill blames youth for running away from bad situation, is punitive, violates civil rights of youth, decreases service use by at-risk youth | 17.3 | 17 |
| **Lack of CD Treatment:** Bill doesn't provide for more treatment, no provisions for locked CD treatment, problems with coerced treatment | 16.3 | 16 |
| **Lack of Secure CRCs:** CRCs still not open, 5-day holding period is too short | 15.3 | 15 |
| **Truancy reporting overburdens schools** | 12.2 | 12 |
| **Overburdened Courts:** Increased workload without resources, court delays lessen impact, not enough follow-through | 10.2 | 10 |
| **Bill Lacks Teeth:** Bill has been gutted, no enforcement, no real consequences to youth. | 7.1 | 7 |
| **Gaps in Bill:** Doesn't include education/prevention, fails to address causes of running behavior, doesn't address role of child abuse/neglect in youth running from home | 11.2 | 11 |

*(Note: The table reflects the number of people giving a certain type of response. Multiple responses were possible so columns do not add up to 100 percent.)*

**Confusion**

The confusion of the legislative language, lack of clarity on how the Bill should be implemented, and the lack of clarity on who was to do what that have already been discussed were cited as important weaknesses of the Bill. Respondents also indicated that there was little technical

information from the state, and in fact, it seemed that no one had any definitive answers. The confusion resulted in misinformation and fueled false expectations of what actually the legislation, or courts, could actually do for parents.

> I just think that there should be a lot more information out there. Families should be more aware of what it can and can't do because many people come in with these expectations that the state will take away their child finally because they want to get rid of them or that the state will take away their responsibility, which it doesn't do. I just think there are a lot of misconceptions, and a lot of people also in the community, professional people in the community, who really shouldn't be throwing out information. They don't know anything about telling people this is the answer to your problems, go file this and see so-and-so in juvenile court. Then they (the parents) come down and they're just mortified when I tell them this is really what it does and really what it doesn't do.
> *Court Respondent*

**Unfunded mandate**

Again, as already discussed, the lack of funding to implement the Bill, and the lack of resources allocated for treatment services was seen as one of the primary weaknesses of the legislation.

**Parent/Family Issues**

The major parent issue cited as a weakness of the "Becca" Bill was that it only focused on the youth and did not address any parental dysfunction or provide the courts with any jurisdiction over the parents.

> ...Overidentified with one component of a family system and violates the rights of another. It doesn't confront a family dysfunctional system, but instead supports it. It would make that family, or components of that family, much harder to work with in a therapeutic environment because they have been empowered farther to the right.
> *Youth Service Respondent*

> I think there could be a little bit more concentration on some parental involvement and parental responsibility. Sometimes I think it's a little bit skewed in terms of painting the children as the problem and the parents as not having a problem when, in fact, I'm not altogether convinced of that.
> *Court Respondent*

> The Bill does not give the courts very much authority over their parents. It was written from the standpoint of parents' rights to try to use the courts to compel their children to do things but when we get those cases in front of a judge what we often see is that there's things that the parents should be compelled to do as well as long as we're gonna be doing some compelling and we just can't do that. For example, we don't have the authority in these proceedings to order a parents to get a psychiatric or a psychological evaluation.
> *Court Respondent*

**Youth Issues**

The perceived impact of the Bill on youth was controversial. Many respondents believed that the legislation has had a positive impact on youth in terms of helping them access treatment or reduce truancy. A substantial proportion of respondents felt that it had a negative impact in terms of punishing youth for running from intolerable or abusive situations, and further, that it further alienated youth and drove them away from receiving services.

> I think the biggest weaknesses and negative effects is that it's a swing in the pendulum towards recriminalizing youth, recriminalizing status offenders ... as exemplified by the involuntary commitment of kids in treatment programs as well as CRCs.
> *Youth Service Respondent*

**Lack of treatment resources**

Respondents indicated that before the "Becca" Bill there was a lack of treatment services for youth. The "Becca" Bill has put into place mechanisms to identify and assess more youth and their need for treatment, but has not allocated more resources to provide treatment to these youth.

> The second *[problem]* is the lack of resources particularly mental health and substance abuse resources and family crisis counseling resources. Those 3 resources in particular. The absence of them is really very disastrous.
> *Court Respondent*

> There's not enough, there are no locked CRCs, there are not enough, there's not enough treatment, inpatient treatment for youth and there's not enough aftercare programs. So I see it as a by-product, you have this lovely Bill and then there's not enough dollars attached to it.
> *DCFS Respondent*

**Truancy**

Although the majority of responses regarding weakness of the truancy component of the Bill focused on the burden placed on schools by reporting requirements, other procedural problems were noted. For example, one problem identified by a court respondent was:

> One of the things we're going to start dealing with is what do you do with these kids that, by local rule, do not qualify to come back to school. Or if they do come back to school, will not get any credit because of all their absences. That's one of the things we've run into -- a judge orders them back to school, the school lets him back in, but technically they've missed so much that they can't earn any credit. So, why be in school if you're not working towards your degree.
> *Court Respondent*

**CRCs**

The lack of secure CRCs, a central component of the legislation, was seen as a major weakness. There also was concern about the process of establishing the CRCs and how they would operate.

> The timelines that are set are unrealistic. Also, I don't see anywhere that it is making sure the basic standard operating procedure --how a secured facility is

operated--is standardized. I think that I should be able to call anyone of the six regions and say, how are you handling this situation. We should all have the same operating procedure manual. I think there's also no monitoring built in. I can't believe that we're going to start x number of secure facilities when we all of this time we could have had a pilot project that was working out all the kinks that could go and train.
*Youth Service Respondent*

**Bill Has No Teeth**

Respondents indicated that they felt the Bill was weak. Different reasons were given, from the fact that under an ARY petition, the courts could only order youth into outpatient and not inpatient treatment, that the youth could figure out ways around the system, that components of the Bill that had given it some bite had been taken out, and that the petition processes only have a short term impact.

I think the weaknesses are simply that those areas that seem needful of implementation are the ones that get cut out, the fact that the Bill is always in flux, that people would challenge, and I guess this is part of the legal dilemma that the lawyers always want to take up a challenge to something that's been implemented.
*CD Respondent*

Couple of factors. One is that there's a limited period of time in which the orders can be effective. And the other one is that you reach the end of your coercive power real quickly. I mean once you've put a kid in detention a couple of times for contempt and not obeying the order, you run out of things to do. You can't say all right this time you're going to a lock up treatment center, now you're gonna stay there till you get cleaned up, you just can't, you're done, you run out of alternatives very quickly.
*Court Respondent*

**Education/Prevention**

Many respondents felt that more attention needed to be placed on providing education prevention resources and addressing risk factors. Also, some indicated that they felt a weakness of the Bill was that it focused on what to do with youth who have run away, rather than addressing the reasons why many youth leave home -- abuse and neglect in the families.

I think from a public policy perspective what it has done has taken the focus off the fact that kids are being abused and neglected and traumatized at an alarming rate and instead of the community looking at that, and saying, you know, what do we need to do to get refocused on that, what they're saying is, okay, clapping their hands together and saying, we handled that, what's next? When in fact, we haven't handled anything. We've delayed dealing with the root issues and we've created a new set of problems.
*Youth Service Respondent*

## Recommendations for Improving the "Becca" Bill

**Table 8: Key Recommendations for Improving the "Becca" Bill**

| Recommendations | % | Number Respondents n=86 |
|---|---|---|
| **Increase Funding for Implementation:** Funding for increased workload for courts, schools, law enforcement, funding for CRCs, more funding for treatment | 41.9 | 36 |
| **CD Treatment Issues:** Increase treatment services/treatment access for youth, more parental involvement in treatment, drop provisions for coerced treatment, create locked CD treatment | 26.7 | 23 |
| **Parents/Families:** Increase parent responsibility/accountability, increase focus on families, not just youth, increase services to families | 24.4 | 21 |
| **Get secure CRCs up and running** | 19.8 | 17 |
| **Prevention/Education:** Add funding/focus on public education, and prevention. | 18.6 | 16 |
| **Simplify/clarify language of law:** Clarify roles/responsibilities of each system, make Bill less bureaucratic | 15.1 | 13 |
| **Truancy Component:** Increase school resources for truancy component, reduce reporting requirements, standardize policies and protocols, provide resources for truancy prevention | 11.6 | 10 |
| **Increase Court Resources and Authority:** Increase court resources/staff, give court more power/in assigning detention, more latitude over parents. | 10.5 | 9 |
| **Provide Other Services for Youth:** Increase assistance to homeless youth, more attention on reasons youth running, increase outreach to kids | 9.3 | 8 |

*(Note: The table reflects the number of people giving a certain type of response. Multiple responses were possible so columns do not add up to 100 percent.)*

Table 8 summarizes the recommendations of the respondents. For the most part, the recommendations follow the criticisms of the Bill. However, it should be noted that there is not a consensus on the legislation and what should be done to improve it. Fundamentally, there is a disagreement about the premise of the legislation -- that there was a need to increase

parental control, which some perceive to be at the expense of youth civil rights and about whether the focus of the Bill on youth as the problem is the right focus. Most respondents did agree that there is a need to address the issues and provide services for at risk youth.

The most common recommendation was more funding be allocated to implement the Bill. The second most common recommendation was that more treatment services be provided. A few respondents indicated that there should be resources allocated to providing locked chemical dependency services, although other respondents indicated that provisions under which youth are admitted to treatment against their will should be dropped. About a quarter of the respondents recommended that the Bill do more to address parental responsibility and accountability. Other recommendations included simplifying the language of the Bill and clarifying implementation procedures, taking steps to reduce the burden on the schools and courts, and providing resources for other types of services for youth that address the reasons why youth leave home.

## IV. PERCEPTIONS OF ADOLESCENT CHEMICAL DEPENDENCY TREATMENT

This last section of the report moves from the "Becca" Bill to focus on respondents' perceptions of adolescent chemical dependency treatment services. We asked respondents their perceptions of treatment effectiveness and treatment accessibility, and asked for recommendations for improving adolescent treatment services for both adolescent outpatient and residential chemical dependency treatment. Many of the comments were similar for the two modes of treatment, although there were some important differences that will be described. Respondents, particularly law enforcement and court respondents, were more familiar with residential programs than they were with outpatient treatment programs. In fact, it should be noted that respondents differed in terms of how familiar they were with treatment programs. The views provided present how treatment is perceived by people from different types of agencies and may be based on misinformation or limited knowledge. The purpose here is to present how treatment is perceived.

### Perceived Treatment Effectiveness

Over half of the respondents perceived adolescent chemical dependency treatment to be moderately to very effective. Overall, however, residential treatment was perceived as more effective than outpatient treatment ($t_{(72)}$=1.18, $p$<.05). Among those who said they were familiar with the two types of treatment, 68% of respondents perceived inpatient treatment as moderately to very effective compared to 58% of respondents regarding outpatient treatment. However, there appear to be some differences in perceptions by type of respondent as shown in Figures 13 and 14. Note that few of the law enforcement respondents were familiar with outpatient treatment, although about two-thirds of them were aware of residential treatment.

Residential treatment was rated as moderately to very effective by over 70% of respondents from chemical dependency treatment agencies and judicial system respondents, and by about half of respondents from youth service agencies, mental health agencies, and schools (Figure 13. Outpatient treatment was seen as moderately to very effective by about 60% of respondents from chemical dependency treatment, mental health, courts and schools, compared to about 40% of respondents from youth service and DCFS (Figure 14).

We compared chemical dependency treatment effectiveness ratings between treatment providers and non-providers, and made these comparisons separately for residential and outpatient treatment. The only difference that emerged was that residential treatment providers rated residential treatment as more effective than did other respondents: 90% of residential treatment providers compared to 64% of other respondents rated residential treatment as moderately to very effective (not shown).

**Figure 13: Perceived Effectiveness of Residential CD Treatment by Respondent Type**

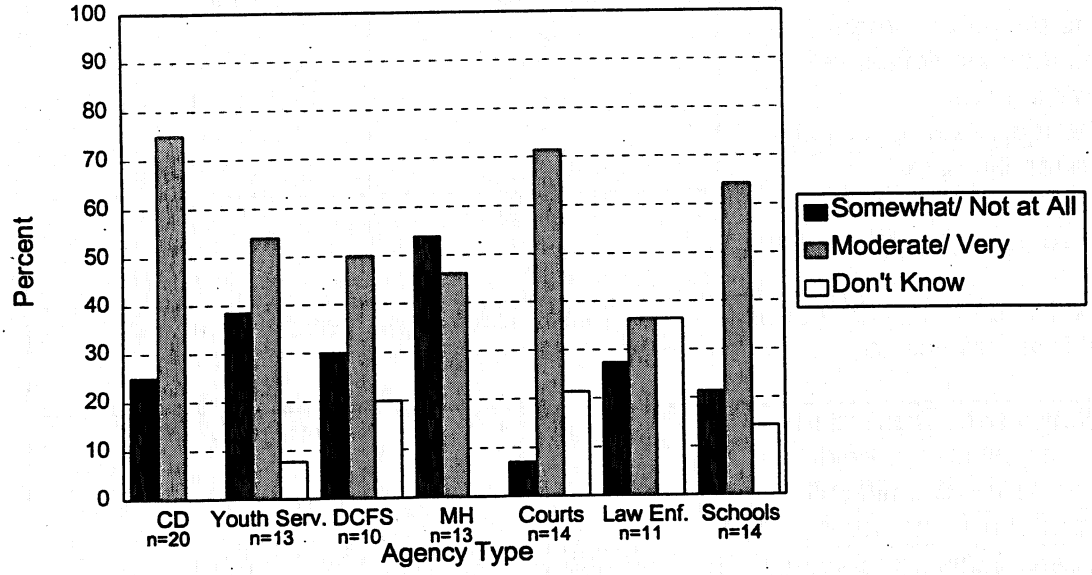
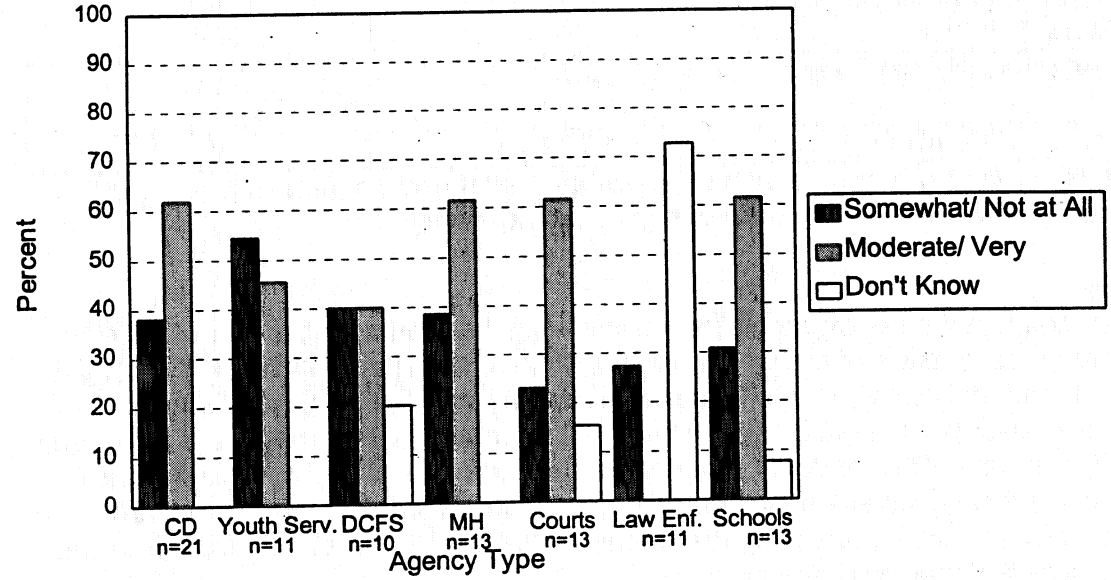



**Figure 14: Perceived Effectiveness of Outpatient CD Treatment by Respondent Type**




Respondents were asked open-ended questions about why they thought treatment was less than very effective. The types of responses given were similar for outpatient and residential treatment, although the emphasis was different for the two treatment modes. The response categories are shown in Table 9.

**Table 9: Perceptions of Factors Affecting CD Treatment Effectiveness**

| | Outpatient n=75 | | Residential n=82 | |
|---|---|---|---|---|
| **Reasons** | **%** | **n** | **%** | **n** |
| **Youth Issues:** Youth don't want treatment, aren't motivated, are in denial, general difficulties working with adolescents | 28.0 | 21 | 18.3 | 15 |
| **Program Models:** Are based on adult models, need to provide alternative to 12-step/abstinence model/disease model, need to be more comprehensive/address whole youth, need to involve family more | 20.0 | 15 | 13.4 | 11 |
| **Treatment Structures:** Programs too short, not intense enough, staff training issues | 13.3 | 10 | 4.9 | 4 |
| **Inpatient more Effective:** Youth need to be removed from drug using environment | 16.0 | 12 | --- | --- |
| **General Problems with Treatment:** High recidivism, agencies not held accountable, for residential: difficulty reintegrating youth back into community | 12.0 | 9 | 36.6 | 30 |
| **Treatment Access Barriers:** distance, transportation, language barriers, cultural barriers | 6.7 | 5 | 9.8 | 8 |
| **Lack of Coordination/Linkages with Other Providers/Schools** | 9.3 | 7 | 9.8 | 8 |
| **Not Able to Address Mental Health Issues** | 2.7 | 2 | 7.3 | 6 |
| **Programs are Underfunded** | 12.0 | 9 | 6.7 | 5 |

*(Note: The table reflects the number of people giving a certain type of response. Multiple responses were possible so columns do not add up to 100 percent.)*

**Youth Issues**

The most common factor perceived to hamper treatment effectiveness cited for outpatient treatment were characteristics of the youth, particularly lack of motivation, their not wanting to be in treatment, and their not viewing themselves as having a problem. About 28% of respondents cited this as hampering the effectiveness of outpatient treatment, and 18% cited it for residential treatment. Respondents commented that treatment could only be effective if youth were motivated and several noted the difficulty of youth accepting that they have a problem when they are not experiencing the chronic health effects that adults experience and do not have a sense of their own mortality.

For an adult, the adults hit bottom, you know they've lost their families, they've lost their professions and they've lost everything and they find themselves in a jail in a drunk tank and finally after many, many years they wake up. It takes an adult a long time to become an alcoholic. It takes a child as little as 6 months to become an alcoholic. But it takes them a lot longer, because of their feelings of invincibility, to realize that they need help.
*Youth Service Respondent*

**Treatment Program Models**

Another common criticism of chemical dependency treatment programs was the types of models they were using. The criticisms were basically of three general categories. One criticism was that the treatment programs were using adult models and were not appropriate for adolescents. Related to this, a second criticism was that they were based too much on a 12-step abstinence model (e.g., Alcoholics Anonymous), which was criticized in terms of not being appropriate for adolescents or not providing enough options. Third, some respondents indicated that the models used were not comprehensive or holistic enough. Several respondents, in particular those from mental health agencies, felt that not enough was being done to address mental health issues or coordinate with mental health treatment providers. Others emphasized the importance of addressing multiple domains including more family services, coordination with schools and other types of programs.

Based on Adult Models

I think youth treatment is still a poor cousin to adult treatment. And that we've just adjusted adult models to sort of fit youth and I think that's a mistake. I think that in a lot of ways it's a band aid approach. I mean we're dealing with kids that are negatively affected by huge social trends and then we get slapped with the job of trying to patch em up because they've got a designated problem which happens to be using drugs. But, really the problems are way more global than that.
*CD Respondent*

Not enough options to disease/12-step model

I think that my answer to that really varies depending on the approach of the treatment program in that, I think that outpatient services directed at adolescents that are solely based on an abstinence model, I would say are probably even less than moderately effective. But, I would say that programs that are more focused on kind of meeting kids where they're at and doing education and more a harm reduction kind of model, I think can be extremely effective.
*Youth Services Respondent*

Not Comprehensive Enough

Second is that all by themselves it's not enough for kids that are having difficulties so I think that that kids need sort of a global approach. It's unusual that something would be going on just with substance abuse and not with family dynamics or not with school or not with the kids' ability to have relationships or perform up to parents' expectations.
*Court Respondent*

Inpatient More Appropriate than Outpatient, Needs to be First Step

Several respondents felt that inpatient was more appropriate than outpatient and that inpatient needed to be the first step in the treatment process, with outpatient providing aftercare and relapse prevention services. One of the most common reasons cited for why inpatient was more appropriate was that it is able to remove youth from drug using peers.

> Well I think that when it comes to adolescents there's a real value to removing them from the community for treatment, for inpatient treatment. Otherwise, if you can get em to show up for outpatient, as soon as they're done, they're out with their using friends again and it doesn't have a lot of impact. It's not a real safe environment. So there's no real safe place to make any changes for them. *CD Respondent*

However, others noted that when youth are removed from the environment, they have re-entry problems or there may not be the support services available in the community when they return and thus they will fall into the same drug use habits.

Issues Specific to Residential Treatment

*After Care/Continuum of Care*

As noted, overall, residential treatment was seen as more effective than outpatient treatment. However, among respondents who gave reasons for why residential treatment was not effective, the most common response was to cite high relapse rates. One of the factors commonly mentioned as contributing to relapse was the lack of aftercare programs. Thus, youth may be doing well in the treatment program, but because there are not aftercare programs to assist with the transition from inpatient to being back in the community, youth relapse.

*Ties to Other Agencies*

Related to this was the perception that there are not strong enough ties between residential and outpatient treatment programs, nor between chemical dependency treatment and other agencies particularly schools and mental health service providers. Respondents noted that youth may become detoxed and leave residential treatment motivated to change their life, and then return to the same environment and do not have a support system established or are not immediately hooked into continued treatment.

*Dually Diagnosed Youth*

Nearly all of the mental health respondents indicated that residential treatment programs were not able to deal with dually diagnosed youth, youth who had mental health issues in addition to chemical dependency issues. This was said to be true of Level II residential treatment agencies, even though they are described by DASA as serving these type of youth. Several respondents said that residential treatment agencies do not want to admit youth with mental health issues, or discharge them for acting out.

> What has happened in many cases is kids can run away, they refuse to be there, they'll assault somebody there and get kicked out. I think most of the kids that we've had there have gotten back out in relatively short order for one of those reasons. They hit a staff, they do something and get charged and then DASA fills the bed and there's no bed to go back to....This agency contracts with a

variety of other organizations for service delivery and as far as I can tell when the going gets tough, we get the kid back.
*DCFS Respondent*

They don't grapple with very complex kids. I mean if kids give even the smallest hint of a behavioral problem, they're out the door. I mean these are tough kids and they don't seem to have the where with all to deal with tough kids. They just boot em out. I mean they only take kids, or they only keep kids, who are extremely motivated to success. Come on, let's get real. You know the kids who need this most are not kids who are gonna be extremely motivated to succeed. Mental health facilities have to grapple with tough behavior. Group homes, whether they're DCFS or JRA, all have to grapple with tough behavior. And I don't see the drug and alcohol treatment facilities grappling with tough behavior; they just boot em out.
*Mental Health Respondent*

They don't like my kids. They're so much trouble. My frustration is that, you know, I have a resource (*book*) for chemical dependency system and several facilities are listed as dual diagnosis and it says specifically they handle both psychiatric and substance abuse problems, but I've never had a kid successful being able to complete one of those programs. The all get kicked out. ...And the reason that's given to me is because they have too many psychiatric problems and I say, but I thought that's what you guys did.
*Mental Health Respondent*

Other Issues

Other less common factors cited as reducing treatment effectiveness were that programs are underfunded, treatment access barriers (which will be discussed below), and problems with program structures such as treatment not being long enough or structured enough. For residential treatment, this criticism was primarily that treatment was not long enough, whereas for outpatient treatment several respondents indicated that outpatient programs were too loose and did not provide enough structure.

## Barriers to Outpatient and Residential Treatment

Outpatient treatment was seen as much easier for youth to access than residential treatment. The accessibility of treatment was rated on a scale of 1 to 4, with higher scores indicating easier access. The mean rating was 2.81 for outpatient treatment and 1.93 for residential treatment which was significantly different (paired t-test $t_{(df=83)} = 7.64$, $p<.001$). Overall, 32% of respondents viewed outpatient treatment to be difficult to very difficult to access, compared to 81% of respondents regarding residential treatment. This is not unexpected given fewer residential treatment agencies, limited number of publicly funded treatment beds, and the higher costs of residential treatment. Responses were similar for both eastern and western Washington respondents regarding treatment access.

As shown in Figures 15 and 16, there do appear to be some differences in perceived accessibility by type of respondent. Law enforcement are less familiar with outpatient treatment than other respondents. Chemical dependency and mental health respondents tended to view treatment access as easier than did other respondents.

**Figure 15: Perceived Ease/Difficulty Accessing Outpatient CD Treatment by Respondent Type**

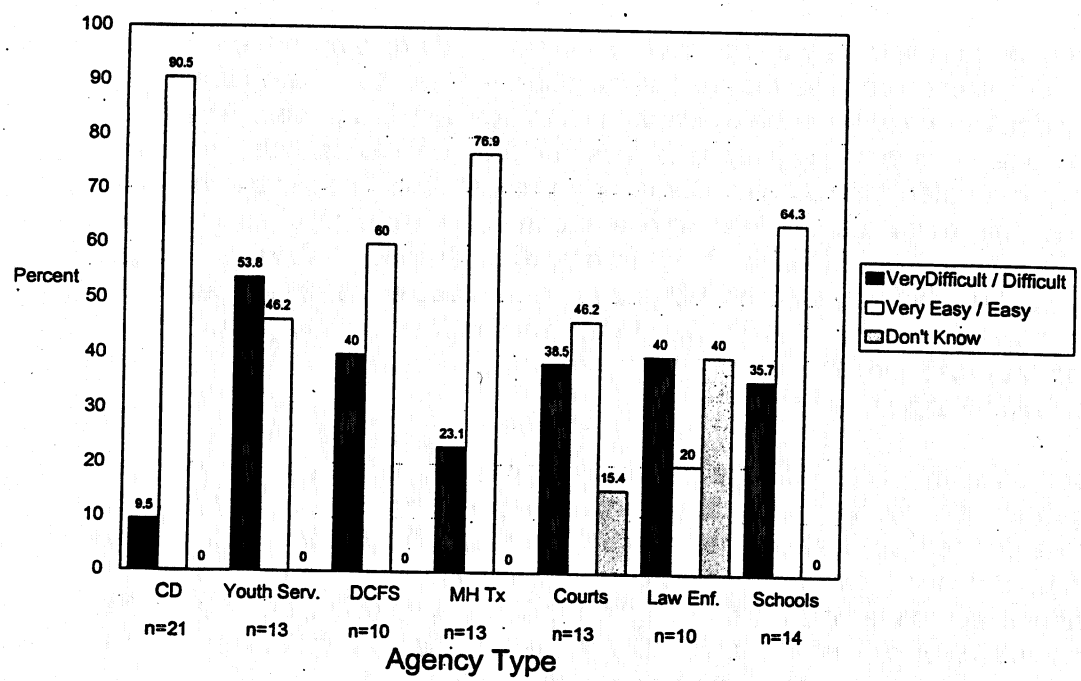
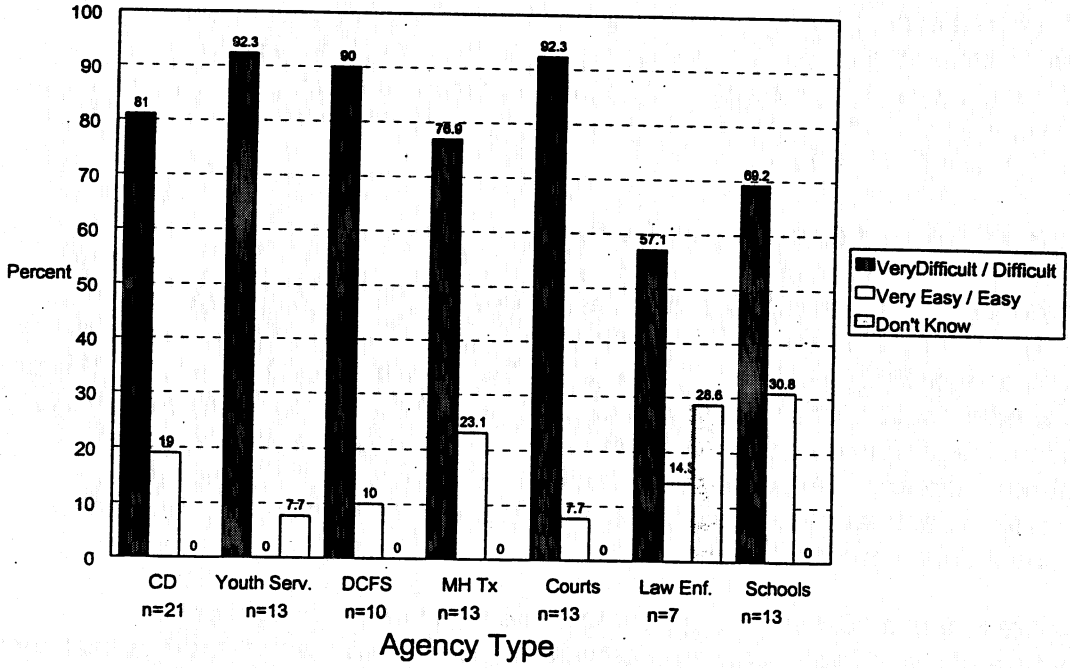



**Figure 16: Perceived Ease/Difficulty Accessing Residential CD Treatment by Respondent Type**



- **The main barriers to youth receiving inpatient treatment perceived by respondents were: treatment availability (68%), funding (67%), and youth motivation (20%).**

- **The main barriers to youth receiving outpatient treatment cited by respondents were: financial barriers (44%) , youth motivation (38%), lack of treatment availability particularly in non-urban areas (23%), and lack of parental support or involvement (23%).**

**Table 10: Perceived Barriers to Outpatient and Residential CD Treatment**

| | Outpatient n=88 | | Residential n=93 | |
|---|---|---|---|---|
| **Reasons** | **%** | **n** | **%** | **n** |
| **Funding** | 44.3 | 39 | 66.7 | 62 |
| **Treatment Availability/Waiting Lists** | 22.7 | 20 | 67.7 | 63 |
| **Admission procedures**: Take too long, too long a lag time, turn youth away | | | 5.5 | 5 |
| **Youth Issues:** Youth don't want treatment, aren't motivated, don't show up (outpatient) | 37.5 | 33 | 20.4 | 19 |
| **Parent Issues:** Lack of parental involvement, support | 22.7 | 20 | 9.2 | 9 |
| **Program Models:** Need programs more appropriate for adolescents, more attractive to adolescents | 4.5 | 4 | 0 | 0 |
| **Treatment Access Barriers:** distance, transportation, language barriers, cultural barriers | 20.5 | 18 | 11.8 | 11 |
| **Lack of Knowledge of Programs** (parents, youth, other providers) | 6.8 | 6 | | |
| **Lack of Coordination/Linkages with Other Providers/Schools:** | 4.5 | 5 | | |
| **Not able to deal effectively with dually diagnosed youth, disruptive youth** | | | 6.5 | 6 |

*(Note: The table reflects the number of people giving a certain type of response. Multiple responses were possible so columns do not add up to 100 percent.)*

For both residential treatment and outpatient treatment, funding and treatment availability were the main barriers to receiving treatment. However, these were emphasized more strongly for residential treatment. Two-thirds compared with less than half of respondents viewed funding as a barrier for residential treatment compared to outpatient treatment, and two-thirds compared with less than a quarter of respondents viewed treatment availability as a barrier for residential compared to outpatient treatment.

For residential treatment, lack of funding and lack of available treatment beds went hand in hand as important barriers to treatment. Access to both residential and outpatient treatment was seen as easy for youth whose parents had the financial resources to pay for treatment, or

whose parents had insurance that would cover treatment costs. There are relatively few treatment beds allocated for publicly funded youth, and there are waiting lists for these beds.

> Well, I think if you can get a kid in when they're ready to go then ... they tend to follow through with it. If you have to wait a long period of time then, like I said before, you lose that window of opportunity and they're less likely to go.
> *Youth Service Respondent*

> I guess all of us are working on this piece about how to get a kid into treatment faster without all the hoops when they need it--- When you finally get a kid ready and they say 'I'm ready to go'-- that you can get them in there without this running up against the block of no space available and having a 30 day wait.
> *School Respondent*

In addition to low-income youth, the "working poor" were seen as another group that were falling through the cracks. These are families who don't meet Title XIX or other public funding assistance criteria, but who nevertheless cannot afford treatment or don't have insurance to cover treatment costs.

> If they're from a wealthy family...I dealt with a family here a few years ago, a wealthy family, it was just like a split second. You got a choice of any treatment center in the state. If they're very, very poor and on medical coupons, you know, that covers the inpatient treatment, if there's no waiting list. But if they fall between the cracks... I would say that the biggest problem is probably with the working poor, I'd say they've got major problems getting' em in.
> *DCFS Respondent*

> Funding is always an issue. Got a kid right now who's, they're low income but they're not Title XIX. Substance abuse benefits for insurance have been exhausted for the lifetime. Kid's still using. There's no money for anybody to see them.
> *Mental Health*

**Access Barriers**

While respondents from some areas, particularly respondents from King and Pierce County, felt that outpatient treatment was readily accessible, respondents from more rural areas indicated that there was a lack of programs close by. Another group for whom treatment availability was seen as a problem was middle school students. As one respondent indicated:

> I get requests from parents and from school staff weekly about the availability of chemical dependency services for kids at the junior high level. You know, they're begging for something. We've tried having agencies provide outpatient treatment on junior high campuses but you know, we have six junior highs and there'll be one kid at one school, two kids at one other school, one over there, you know, how do you bring those kids to a place where you know, your treatment is cost effective. How do you do that? It's real hard.
> *School Respondent*

Related to this, transportation was noted as a barrier in rural counties as well as for middle school students. For residential treatment, there was not a consensus on whether treatment facility location was a barrier. Some respondents felt that not having a residential facility close by was a barrier in that parents did not feel comfortable placing their children too far away or at a place they are not familiar with while others noted that some parents preferred to have their child placed outside of the community to protect confidentiality.

**Youth Issues**

Youth not wanting treatment, or not showing up for treatment, was also cited as an important barrier to treatment, although somewhat more strongly for outpatient than for residential treatment.

> I would say a big one is the child being willing to actually go through with the treatment because I have seen a number of children get either coerced by their parent into treatment, if they kind of agreed but weren't really into it, or they were court ordered into some form of treatment. That doesn't work. They may have needed that kind of treatment but it's definitely the kind of problem where you need to be committed to it within you own person to make it work.
> *Court Respondent*

> ...from every outpatient provider I've talked to, biggest problem is you can't get the kid to even show up. So your groups are haphazard. Sometimes they're there, sometimes they're not. There's hardly ever any trust built and so good group work can't take place because you know, different people bobbing in and out, real superficial level, and I think that can't happen except on an inpatient level for adolescents.
> *CD Tx Provider*

**Lack of Parental Support/Involvement**

The lack of parental support or parental involvement in the youth's treatment was also cited as a barrier. Sometimes the parental lack of involvement was related to the parents own substance use.

**Programs Not Admitting Youth with Mental Health/Behavioral Problems**

Another barrier cited for residential treatment was that residential treatment facilities are not admitting youth who have mental health problems, or making the admission process more difficult, as was already discussed.

Other barriers to outpatient treatment that were mentioned were: language and cultural barriers, lack of awareness of parents and youth of available services and how to access them, and lack of cooperation or coordination among different service providers. The lack of secure (locked) residential treatment facilities was also cited as a barrier by a few respondents.

## Respondent Recommendations

Respondents were asked what recommendations they have for improving both outpatient and residential treatment. Although there were some common elements in the recommendations for outpatient and residential treatment, the emphasis and nature of the responses were different and thus they will be discussed separately.

**Table 11: Respondent Recommendations for Outpatient and Residential Treatment**

| | Outpatient n=73 | | Residential n=76 | |
|---|---|---|---|---|
| **Reasons** | **%** | **n** | **%** | **n** |
| Increase Funding for Treatment | 27.4 | 20 | 27.6 | 21 |
| Increase Treatment Availability: | 12.3 | 9 | 53.9 | 41 |
| Improve Treatment Access: | 19.2 | 14 | 19.7 | 15 |
| Improve Treatment Models | 27.4 | 20 | 13.2 | 10 |
| Improve Program Structures | 17.8 | 13 | 15.8 | 12 |
| Increase Outreach and Linkages with Other Agencies | 39.7 | 29 | 22.1 | 17 |
| Increase Program Accountability | 4.1 | 3 | 6.6 | 5 |
| Improve Ability to Deal Effectively with Dually Diagnosed Youth | 0 | 0 | 11.8 | 9 |

*(Note: The table reflects the number of people giving a certain type of response. Multiple responses were possible so columns do not add up to 100 percent.)*

**Outpatient Treatment Recommendation**

**The top five recommendations for outpatient treatment were :**

- **Improve outreach and coordination with other service providers particularly residential treatment, mental health treatment, and schools; provide case management**
- **Increase funding**
- **Improve treatment models used**
- **Increase treatment access (particularly in non-urban areas)**
- **Improve program structures such as increasing treatment length and intensity; improve staff training**

Three fourths of the respondents (73/98) provided some recommendation for improving outpatient treatment. The most frequently mentioned recommendation was to increase community outreach and linkages with other service providers, including schools, mental health providers, inpatient treatment. Related to this, several respondents indicated the need to provide more coordinated after-care programs and greater community education and outreach. In discussing the need for more coordination between service providers, several respondents suggested that there needs to be funding allocated to outpatient providers to provide case management.

> I think there needs to be closer coordination with the school and the outpatient treatment program.
> *School Respondent*

> If we were able to, and this is really kind of a funding issue, but if we were able to do case management the way we feel like we need to do it, it would really improve youth treatment tremendously. Kids that are on med coupons or that we serve through our county low income contract, there is no funding category

for case management, and so it really limits us. Whatever case management we do, we do for free.
*Chemical Dependency Treatment Respondent*

I'd like to see it more run holistic and I think it should have some mental health basis in it also to work with the issues kids are bringing up around their chemical dependency and why they're using, that they take more of a holistic approach and I encourage chemical dependency folks to look at case management model and do outreach more and play and have a better relapse program for kids.
*Mental Health Respondent*

I would say the number one thing that I think would be helpful is if it was really approached on a dual diagnostic level, that you didn't just separate out mental health and family issues from substance abuse because I think they're all part of one in the same and so I would say just greater accessibility by expanding the services available.
*Youth Service Provider*

**Improve Treatment Program Models**

As discussed earlier, treatment models used by programs were criticized as not the most appropriate models for adolescents, too narrowly focused and not providing enough options, and needing a stronger family systems approach with more family involvement. Recommendations to address these issues included holding focus groups with youth to find out what they saw their needs to be, basing treatment models on empirical evidence of what works with adolescents, developing models that are more appropriate for adolescents, providing options to the 12-step abstinence based models to better meet youth where they are and increase their motivation, and to expand the focus of treatment to incorporate the whole youth and not solely focus on substance abuse.

I think what I would do, if I were DASA, I would put together focus groups for, made up of young people throughout the state and listen to them, see what works for them. For kids who are need of treatment, who are receiving treatment and who have received treatment, both positive and negative accounts, to do focus groups with those kids and to listen to them.
*Youth Service Respondent*

The models that they use, they have to be adapted to serve the life of the teenager. ...They are too adult centered and I think they have to be creative on those things.
*DCFS Respondent*

I think that the goals of the outpatient program with the individual are unclear, that quite often in the outpatient programs they end up being the treatment model of a rap group and so I think it's a little too unstructured in terms of what is it that we're trying to accomplish, what does support mean? And that varies from treatment program to treatment program or outpatient program to outpatient program even intervention specialist to intervention specialist.
*School Respondent*

> More research into other forms of treatment, consider other models outside of cure/disease.
> *Youth Service Respondent*

> I think that we have some pretty skewed images and expectations of what that kind of intervention is supposed to do. I've been doing this for 20 years and have been livin' in the neighborhood for longer and quite frankly I don't see many 15 year olds that really have an active addiction and go into some treatment program and never, ever, ever again picked up a chemical. And that seems to be the standard and the whole focus of how programs even tell kids, this is how you know you're successful. ...If you've got a clean UA for the rest of your life....I don't think it's the healthiest model.
> *Youth Service Respondent*

> I think we need to make sure that we're treating the whole child, that we really are working from a research base, like the risk factor reduction, that we're also working with the child in their school setting, home setting as well as their individual moments.
> *Mental Health Respondent*

**Accessibility**

Several respondents recommended that there needs to be more outpatient treatment throughout the state and programs closer to non-urban areas. As noted earlier, transportation was seen as an important barrier. Recommendations were made to have more on-site school programs, or to have programs provide transportation.

> Maybe having them more on site at high schools and junior highs. I think they'd be easier to access because the kids are right there and if transportation's an issue it'd be right there on site. And I know there are some high schools that have someone that will go to the school and evaluate the kids.
> *DCFS Respondent*

To address the issue of language barriers, it was recommended that agencies have more bilingual staff, and provide more training for culturally sensitive programming.

## Residential Treatment Recommendations

**The top five recommendations for improving residential treatment were:**

- **Increase treatment availability**
- **Increase funding for residential treatment**
- **Improve aftercare services and linkages between residential CD treatment and other service providers**
- **Improve treatment access**
- **Improve program structures such as providing longer treatment and improving staff training**

**Treatment Availability and Treatment Funding**

Seventy eight percent of respondents (76/98) gave some recommendation for improving residential treatment. Increasing treatment availability was the most common recommendation and was emphasized by respondents from all systems. Again, respondents stressed the importance of being able to provide treatment on demand for adolescents to take advantage of the narrow window of opportunity when a youth indicates openness to treatment. Some of the CD treatment providers noted that to increase treatment availability meant that additional publicly funded treatment programs were needed because some of the existing programs were already at the maximum number of treatment slots their facility could accommodate. Several people also indicated that there was a need for secure (locked treatment facilities). Increased publicly funded treatment was recommended as discussed earlier.

**Improved After Care Services and Case Management**

There was a shared perception across types of respondents that there needs to be more aftercare services provided to youth leaving residential treatment. Some respondents felt that chemical dependency treatment programs need to do more outreach and education with other providers, and that more follow-up needs to be done by CD treatment providers to make sure that youth make it to service referrals. Specific interagency linkages that were cited were to improve coordination and cooperation between inpatient chemical dependency treatment and outpatient chemical dependency treatment, mental health treatment, and schools.

A related recommendation was that funding be allocated to chemical dependency treatment providers to do case management. As was discussed for outpatient, both chemical dependency and mental health treatment providers noted that there was currently no funding for case management. Treatment planning and providing aftercare services for adolescents is more time intensive and involves more intensive follow-up than for adults. Case management was viewed by treatment providers as a critical component to effective treatment for adolescents.

**Improved Treatment Access**

The majority of the responses to improving treatment access concerned increasing the number of programs in rural smaller communities so that youth would not have to go so far from home. However, a few of these responses also indicated that treatment programs needed more staff who were bilingual and for programs to be more culturally sensitive. Some respondents did indicate that they felt programs, particularly in King County, had made great strides in making programs more sensitive to cultural, sexual orientation, and gender differences.

**Improve Treatment Structures and Staff Training**

There were a range of recommendations made that referred to improving or modifying program structures. The most frequent recommendation under this category was to increase the length of the treatment, with several people commenting that 28-30 days was not long enough to address the multiple problems these youth face. Other recommendations included increasing the amount of structure in the treatment programs, revising the criteria and structure of Level I and Level II treatment programs, and reducing the size of the programs so that more individualized and intensive treatment can be provided.

Although several respondents indicated that staff at some of the agencies do very good work, others suggested that there is a need at some agencies for staff training, particularly in the areas of managing behavioral problems, youth with mental health issues, and ways to make treatment more appropriate for adolescents.

**Other Recommendations**

Increase Program Accountability

Other general recommendations made included that programs be made more accountable and outcome evaluations conducted, for both residential and outpatient.

Improve Treatment Models

Comments on improving treatment models was similar for residential treatment as discussed for outpatient treatment. However, the major emphasis was on using more family systems models and involving the family more in treatment.

Increase Ability and Willingness to deal with Dually Diagnosed Youth

As noted earlier, the perception, particularly of mental health respondents, is that chemical dependency residential treatment programs are unable or unwilling to admit and retain dually diagnosed youth. It was recommended to address this issue that better working relationships be developed between chemical dependency and mental health providers, and that staff receive more training and support to deal more effectively with these youth.

## CONCLUSION

From the interviews with key informants across multiple systems, it is clear that there are disparate perspectives on the wisdom of the "Becca" Bill and on its impact on youth and parents. Most of the respondents agreed that something needs to be done for runaway and at risk youth; there was less agreement on what and how it should be done.

One issue centers around the role of parents. In general, people felt that the Bill had a more positive impact on parents than on youth. The most frequently cited strength of the Bill was that, with the threat of the court sanctions behind them, it increased parental control and authority over their children as well as increasing parental access to treatment for their children. However, one of the commonly cited weaknesses of the Bill was that it went too far increasing parents control without increasing parental accountability. The problems of runaway/at-risk youth are rarely the result of problems with the youth alone but rather are a function of dysfunctional patterns within the family system. Recommendations from respondents included giving courts more authority over parents such as the ability to order drug treatment for parents as one of the petition conditions and including parent or family evaluations when evaluating youth.

A second issue about which there were discrepant views centered around placing youth in locked facilities and in treatment against their will or without their consent. Some of the respondents believed quite strongly that some of these youth are so out of control that the only way to keep them from running long enough to help them is to place them in secure facilities where they can have a time to "chill out" and where they can be evaluated. Similarly, some believed that denial is part of the addiction disease and that for some minors the only way they will get into treatment is if they are placed their against their will.

Other respondents, particularly those from shelters and youth services but certainly not limited to those respondents, believed equally strongly that placing youth in locked facilities or in treatment against their will was counterproductive, further alienated youth and drove them more "underground". Some of these respondents felt that locked facilities may be necessary for some youth who were at great danger to themselves or other, but that this was only a very

small proportion of runaway or at risk youth. Many respondents believed that treatment would only be effective if youth were motivated, and that placing youth in treatment against their will was essentially pointless. In fact, lack of youth motivation was one of the most commonly cited barriers to effective treatment. Innovative programs and strategies to work with youth, increase their motivation and treatment readiness, and methods for retaining youth in treatment, are needed.

It should be noted that all but one of the youth that were admitted to residential chemical dependency treatment under the provisions of the "Becca" Bill (e.g., ARY, CHINS, truancy petition) gave their consent for treatment (Peterson, 1997[5]). However, signing consent forms and being motivated or ready for treatment are not the same thing. It was beyond the scope of this evaluation to more directly assess the impact of the legislation on runaway or at-risk youth. However, this is a critical missing piece and warrants investigation.

There was somewhat wider agreement as to implementation barriers. One of the most frequently endorsed barriers was the lack of shelters or other youth services and the lack of secure crisis residential centers. Frustration was expressed by many that one of the centerpieces of the legislation, the secure crisis residential centers, were not in place. Law enforcement officials in particular felt that without the locked CRCs, nothing had changed because there was still no place to take youth. However in general there was the strong feeling that there are not enough safe places or services for at risk youth.

Another important barrier was the lack of resources allocated for implementing the Bill. This was most strongly articulated by school and court respondents for whom the workload increased dramatically without an increase in resources due to the demand placed on courts in adjudicating the ARY, CHINS, and truancy petitions, and on schools in meeting reporting and petition requirements. The most frequent recommendation by respondents was that in order for this legislation to be implemented effectively, more resources were needed.

Respondents across systems recommended that more resources be provided for publicly funded chemical dependency treatment for youth. Placing youth on waiting lists for treatment was seen as a major problem, resulting in losing youth and missing windows of opportunities to intervene. Outpatient treatment was viewed as more accessible than inpatient treatment, but particularly in rural areas, the lack of programs close by was seen as an important barrier.

Overall, chemical dependency treatment was viewed as moderately to very effective, with residential treatment viewed as more effective than outpatient treatment. However, in addition to increased treatment availability, several recommendations were offered for improving treatment services. One frequent recommendation was that treatment program models be changed to provide treatment that is more appropriate for adolescents, provide more family systems based treatment, and provide alternatives to the 12-step or disease models.

A second recommendation was that the chemical dependency treatment programs do more outreach and work more closely with other agencies including school, outpatient treatment, and mental health treatment providers. Primary concerns were that there needs to be more after-care programs, case management, stronger linkages between residential and outpatient programs, and improved services for dually diagnosed youth. There was a perception among many respondents that chemical dependency treatment programs are turning away, or not able to retain, youth with mental health or behavioral problems.

Key informants were selected for their knowledge or involvement in the implementation of the "Becca" Bill, and not their knowledge of chemical dependency treatment programs. Thus, their views may not be based on accurate information. Nevertheless, the consistency and conviction with which some of these views or concerns were expressed suggests that they warrant examination and discussion. It also suggests that at the very least there is a need for more outreach and education about chemical dependency services, treatment models, and admission procedures and requirements.

NOTES:

[1] There was one exception. Snohomish County was not selected even though it would have qualified based on the number of admissions. A similar interview among similar respondents had been conducted in the County just prior to the start of this evaluation project (Snohomish County "Becca" Bill Task Force, 1995).

[2] This was not, in fact a change in chemical dependency treatment policy. Parents had been allowed to admit their children to residential treatment agencies even if the youth did not give their consent, but it was strongly recommended that treatment agencies always try to obtain youth consent.

[3] Becca Too changed the timeframe holding a fact-finding hearing within 5 judicial days if the child is on the run and 10 days if the child lives in the home.

[4] Only two of the seven mental health, youth services, or school respondents who reported that their agencies provided outpatient chemical dependency treatment services were asked the questions about the impact of Becca youth on chemical dependency treatment agencies, and only one, which was not listed as a certified chemical dependency treatment program, had admitted a Becca youth. Thus, none of these agencies were included in this section of the report.

[5] Peterson, P. (1997) "Evaluation Report on the Appropriateness of Treatment: Youth Admitted to Residential Chemical Dependency Treatment Under the 'Becca' Bill." Report prepared for Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services.